community health
northwest florida
HealthcareWithinReach.org

Please read carefully, and fill out the Consent Form below in order to receive student health services from Community Health Northwest Florida. An attempt will be made to contact the parent/guardian at the time of service.

Patient Name:_____**Phone:** _____

Address: _____
Street City State Zip

Birthdate:_____**S.S. #**_____**Grade:**_____**Gender:** _____Male_____Female

Parent(s)/Legal Guardian:_____**Parent DOB:**_____**Phone:** _____

Ethnic Group: Hispanic/Latino _____ Non-Hispanic/Latino_____

Race: Asian _____ Black/African American _____ White (including Latino/Hispanic) _____ American Indian _____
Other Pacific Islander_____ More than one race_____ Unreported_____

MEDICAL INSURANCE INFORMATION (Please check all that apply and/or provide copy of card.):

Medicaid number: (additional copies of card may be required)

_____CHIP (Children's Health Insurance Program) number:_ __

_____Medical insurance: _____Policy # _____ Phone #:_ _____

The patient is uninsured and I would like information regarding reduced fees (sliding fee) and/or CHIP.
Gross Family Income per month: Family size: _____
_____

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information. Please note that there is an attached copy of HIPAA information to this consent form, for the parent/guardian of the student receiving medical or mental health counseling services at Community Health Northwest Florida. I certify that a copy of the Health Insurance Portability and Accountability Act of 1996 was provided with the Community Health Northwest Florida consent form, to the parent/guardian of:

Signature of Patient/Parent/guardian Date Signature of Health Center Staff Member Date

---

The services of the health center are provided in partnership with
Community Health Northwest Florida and the Escambia County School District.

PLEASE RETURN THIS SIGNED CONSENT FORM TO YOUR SCHOOL.

- **I, the parent or legal guardian, give consent for any of the treatment-related health services listed on this form, while my child is a student of the Escambia County School District.**
- **I understand that Community Health Northwest Florida's services will be located at my child's school.**
- ***I understand that the services provided by Community Health Northwest Florida are based on my insurance plan. I am responsible for any amount NOT paid by my insurance. Initials: _____**
- **I consent for my child to receive immunizations Yes___ or No___**

I agree that the health center may release information regarding treatment services provided to third party payors for billing purposes, and to my child's regular health care provider. I understand that services may include nursing care, medical treatment, and referral for counseling; and that all health care information is confidential. Routine information that is part of the school health record may be shared with the school nurse. Other information will only be shared with persons outside of the health center staff with parental or guardian consent. *I may withdraw consent at any time by contacting any member of the staff in writing.* I understand that routine services such as sports physical exams, treatment of acute illnesses, immunizations and provision of over-the-counter medications **(i.e. Tylenol) may be provided without prior notification of parent**. I have received a copy of the Health Center's Privacy Policy.

Signature of Patient/Parent/Legal Guardian Date

<u>REFUSAL OF CONSENT</u>: I *do not* wish for my child to utilize Community Health Northwest Florida Mobile Medical Unit.

Signature of Patient/Parent/Legal Guardian _ Date: