Table Rock Elementary School ~ School-Based Health Center (SBHC)
Consent for Health Care Services

2830 Maple Court,White City, OR 97503

Table Rock Elementary SBHC is operated by the Rogue Community Health (RCH) in collaboration with the Jackson County School District 9

Patient Name: _____ Grade: _____Date of Birth: _____

Address: _____ZIP_____ Phone: _____ ☐ Parent ☐ Student

Who does student live with:_____ Preferred Spoken Language: _____

Agreement: Please read carefully and sign at the bottom.

Consent for Treatment:

I consent to treatment necessary for the care of the above named patient. I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I allow fax transmittal and/or HIPAA secure electronic submission of my medical record, if necessary.

I give permission for my student to take over the counter medication (such as Tylenol, etc.) □ Yes □ No ***Initial*: _____**

***List allergies:* _____**

Financial Responsibility:

All patients with self-pay accounts or co-pay requirements are asked to bring in payment at each visit. Patients that have made payment arrangements and/or received a monthly statement are asked to make a payment within thirty days of the statement date. If you have payment concerns, please notify the billing department. We will bill your insurance for you. However, your account remains your responsibility.

Insurance Information: ☐ No Medical Insurance ☐ Private Health Insurance ☐ OHP ☐ Unknown

Name of Insurance Subscriber:_____ Date of Birth: _____

Name of Medical Insurance: _____ ID#:_____ Group #:_____

Insurance Address: _____ Phone #:_____

If not insured, would you like to be contacted someone for no or low-cost health coverage for children? ☐ Yes ☐ No

Insurance Authorization:

I understand the financial policy above and accept financial responsibility. By signing below, I assign RCH all payments due from my insurance company for services rendered.

NO ONE IS TURNED AWAY FOR INABILITY TO PAY ~ Students will receive many services without a fee.

Medical Home

RCH has a model of care called a Patient Centered Medical Home. This means the clinic is a health care setting where the patient works in partnership with the care team to address all health care needs.

- Does the patient have a regular Doctor (PCP)? ☐ Yes ☐ No

If yes, I authorize RCH's SBHC to release health information to primary care provider. Name of Doctor: _____

- I would like RCH/SBHC to patient's primary medical provider? ☐ Yes ☐ No

Release of Information: Do we have your permission to:

- Leave message on your answering machine at home? □ Yes □ No
- Leave a message on your cell phone? _____(number) □ Yes □ No
- Leave a message at your place of employment? _____(number) □ Yes □ No
- Discuss your child's medical condition with any member of your household? □ Yes □ No
  If yes, □ Anyone □ Specific: _____

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These agreements will remain in effect for 2017-2018 School Year or until revoked by me in writing. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

_____ _____

Signature of Parent or Guardian Parent or Guardian (Please print)

_____ _____

Relationship to Patient Date