Teacher:
Grade:

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

MRN: PCP:

School Based Health Services Consent Form

Before your child sees a provider, we are asking you to authorize medical and/ or dental treatment. We will work with you to improve your child's medical and dental health needs and are happy to work with your primary doctor, nurse practitioner or dentist. Our goal is to ensure that your child's medical and dental care needs are met so that he or she has the best possible outcome and receives care when it is needed. * *These dental services are free to children without insurance. If your child has dental insurance that covers this procedure, we will bill your insurance for the cost of this service, but it will remain free to you. ** All services are not available at all schools, and any student can be seen at any School Based Health Center in your school district.

By signing this consent form, I give permission for my child to receive the following services:

- Over-the-counter medications (e.g. Tylenol, Advil, etc.) for symptom relief
  I consent to this service Yes________ No _________ *Parent/Guardian Initials* ________________

List known allergies (medications/foods/other) and reactions ____

- Dental sealants along with a visual screening does not replace a complete dental exam done by a dentist. This visual screening does not result in a diagnosis or a treatment plan, serious oral health problems may be missed.
  I consent to this service Yes_________ No__________ Parent/Legal Guardian Initials____________

- Fluoride varnish with a visual dental screening does not replace a complete dental exam done by a dentist. This visual screening does not result in a diagnosis or a treatment plan, serious oral health problems may be missed.
  I consent to this service Yes_________ No_________ Parent/Legal Guardian Initials____________

Authorization of Payment: I assign and authorize direct payment to La Clinica of all insurance and plan benefits that are payable for service(s) I receive and also authorize release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Notice of Privacy Practices: I acknowledge receipt of La Clinica's Notice of Privacy Practices. This notice is provided the first time I receive services from La Clinica and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of La Clinica's Patient Rights and Responsibilities.

________ (Please initial here) In La Clinica's school-based health Services, protected information will be used or disclosed only when it is necessary to satisfy a particular purpose or carry out a function related to health and protection of a child's well-being and ability to learn and succeed.

I authorize the care team of La Clinica to administer to ____ **such**
(Patient's Full Name) (DOB)
medical and dental treatment as it deems necessary.

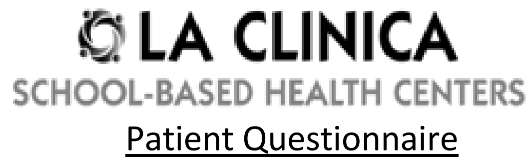
____ ____
Legal Guardian Printed Name *Relationship to Patient*

____ ____
Legal Guardian Signature *Date*

La Clinica School-Based Health Centers provides primary and preventive medical care for students as agreed by its partners: La Clinica, Asante Health System, Providence Medford Medical Center, Medford School District 549C, Central Point School District #6 and Phoenix/Talent School District #4 (policies available upon request). The dental health screenings provided through this program is a brief visual exam and does not take the place of a complete dental exam done by a dentist. La Clinica provides these dental services through support from the Walker Fund and through contributions by Oral Health America.

Student Name:
DOB:
Teacher:
Grade:

MRN: PCP:



Patient Questionnaire

1. Does your student have a doctor or family nurse practitioner he or she sees regularly?
2. □ Yes □ No, if yes: Name of Doctor/Nurse Practitioner: _________________________
3. Preferred Pharmacy: ____
4. What medications does your student take regularly? Please include over the counter medications, supplements and inhalers. ____
5. Does this child have any behaviors that may impact our ability to provide care to him/her?:____
6. History of other medical problems: ____

   ____
7. Does your student have a dentist he sees regularly? □ Yes □ No
8. Name of Dentist: ____
9. When was the last time your student saw a dentist? (please circle one below)

Less than 12 months over 12 months never seen

Signature___________________________________ Print name ________________________________Date_______

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MRN:	PCP:	Date:

Teacher:
Grade:

SCHOOL-BASED HEALTH SERVICES

www.laclinicahealth.org/school

La Clinica is able to help our patients offset the cost of health services due to grant support from the government. As a result, we are required to gather income and household information for each of our patients. We realize this is very personal information and we will continue to protect your confidentiality with this information as well as with your personal health information.

La Clinica School-Based Health Centers provides primary and preventive medical care for students as agreed by its partners: La Clinica, Asante Health System, Providence Medford Medical Center, Medford School District 549C, Central Point School District #6 and Phoenix/Talent School District #4 (policies available upon request). **The dental health screenings provided through this program is a brief visual exam and does not take the place of a complete dental exam done by a dentist. La Clinica provides these dental services through support from the Walker Fund and through contributions by Oral Health America.

Patient's Full Name:	DOB:	SSN:
Parent/Guardian Name: DOB:	Relationship to patient:	
Address:	City:	ZIP Code:

Home Phone:	Cell Phone:	Work Phone:	Name of Employer:	Full-Time / Part Time (circle one)
Emergency contact/phone number:			May we leave detailed information on your answering machine/voice mail: ☐ Yes ☐ No	
Child's Insurance Information – *please provide a copy of your insurance card*			☐ My Child does not have **medical** insurance ☐ My Child does not have **dental** insurance	

Medical Insurance Company Name:	ID #	Group #
Insurance Billing Address:	Name of Primary Insured:	Insured DOB:
Dental Insurance Company Name:	ID #	Group #
Insurance Billing Address:	Name of Primary Insured:	Insured DOB:

Question	
Are you and your family members living in someone else's household? ☐ Yes ☐ No (*includes couch surfing*)	#3
In the past 2 years, have you or someone in your household lived in one of the following: foster care, motel, shelter, group home, recovery center, or jail? ☐ Yes ☐ No	#2
In the past 2 years, have you and your family been forced to move into a temporary situation because of housing costs? ☐ Yes ☐ No	#7
Are you and your family members living in one of the following: camp, street, bridge, shelter? ☐ Yes ☐ No	#4
Are you and your family members currently not homeless, but were in the last 12 months? ☐ Yes ☐ No	#5
Are you and your family members living in public housing? ☐ Yes ☐ No	
Have you or anyone in your household worked in any of the following industries: crops/harvesting, farming in any capacity, packing house, aquaculture, orchards, fertilizing/turning of soil, reforestation, vineyards? ☐ Yes ☐ No If yes: 1) Did you work in the industry in the past two years? ☐ Yes ☐ No 2) Did your family ever move to accommodate your work? ☐ Yes ☐ No 3) Have you or a member of your household ever had to stop working in this field due to a disability? ☐ Yes ☐ No	

Is the patient disabled? ☐ Yes ☐ No	Please select the patient's ethnicity: ☐ Hispanic ☐ Non-Hispanic
Please select the patient's race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian *(check all that apply)* ☐ Native Hawaiian ☐ Pacific Islander	

*** Please complete this form entirely. Incomplete forms will not be accepted.**

If you have Insurance, we will bill it for eligible services

For staff use: Patient ID number:____________Health-care provider_____Date_____

Welcome to La Clinica. We want to help you keep the cost of your visit as low as possible and would like to offer you the opportunity to apply for financial help through our income-based sliding scale program. We understand this information is sensitive and want you to know we limit access to it and prohibit sharing of it.

Please complete the following:

Number of people in my family ________________

My family's monthly income____________ or **My family's annual income (last 12 months)** ________________

☐ **I wish to apply for La Clinica's sliding scale (we will ask you to provide additional financial details).**

☐ **I do not wish to apply for the sliding scale. (I don't think I'm eligible and/or I don't wish to provide my income information.)**

The information I have provided here is truthful and accurate to the best of my knowledge.

Signature_________________________________Printed name______________________________Date ____________

NOTICE OF PRIVACY PRACTICES

Effective Date: May 4, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Ida Saito, Operations Officer of La Clinica at (541)535-6239, 3617 South Pacific Hwy Medford, OR 97501

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Disclosures of Protected Health Information (PHI) to other health care providers for treatment purposes may be made through computer networks, or other means of communication.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures if you are unavailable or due to your health condition. We will request your permission at the point in time you are available or able to grant permission.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

La Clinica is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN). A current list of OCHIN participants is available at www.ochin.org. As a business associate of La Clinica, OCHIN supplies information technology and related services to La Clinica and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by La Clinica with other OCHIN participants when necessary for health care operations purposes of the organized health care arrangement.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not contact you for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office unless it is determined by our *Institutional Review Board* or *Privacy Board* that your privacy will be protected as part of the research and it may interfere with the research if you are contacted. We will offer you the option of opting out of any research related to genetic studies.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose patient health information if we suspect abuse, neglect or domestic violence as required or permitted by law.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Specialized Government Functions.** We may disclose patient health information to government agencies with special functions as required or permitted by law.

  Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

  Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We will ask for your permission to disclose your health information to family members and friends as soon as you are available or capable of giving consent. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written *Authorization*.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV/AIDS, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Ida Saito, Operations Director in order to inspect and/or obtain a copy of your health records. If you request to inspect or view your health information, we will not charge you for inspection or viewing.

  If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  You have the right to request an electronic copy of your record if we maintain all or part of your record electronically. You are only entitled to ask for a copy of that part of your record we store electronically. You may be charged for our staff costs to create the electronic copy. We will notify you of the cost at the time of your request and you may choose to withdraw or modify your request at that time.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review. You are not entitled to copies of psychotherapy notes.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a Medical Record Amendment Form to Ida Saito, Operations Director.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 1 page in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to Ida Saito, Operations Director. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to be notified following any unauthorized disclosure of your protected health information. It is our intention to notify you immediately following the discovery of a breach of your protected health information.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family

member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

In most cases we are not required to agree to your request**.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information. You can revoke any honored restriction requests at any time. Such requests must be in writing.

We are required to honor your request if you paid for diagnosis, treatment, medical equipment, etc. "out of pocket." Also, we are required to honor your request if the request is to not disclose your health information to your health insurance plan for payment or healthcare operations. If you request we not provide your health information to your health plan for payment purposes, we may require you to pay in-full for any services or supplies provided at the time of service.

To request restrictions, you may complete and submit the Authorization to Release Information with your modified request to Ida Saito, Operations Director.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the Patient Request for Confidential Communication form to Ida Saito, Operations Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Revoke Your Authorization.** If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. [*You may also find a copy of this Notice on our web site.]*

  To obtain such a copy, contact Ida Saito, Operations Director.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date on the top center. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our practice newsletter, a sign prominently posted in our office, a notice posted on our web site or other means of communication.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X
U.S. Department of Health & Human Services
2201 Sixth Avenue - Mail Stop RX-11
Seattle, WA 98121
(206) 615-2290 (VOICE)
(206) 615-2296 (TDD)
(206) 615-2297 (FAX)

To file a complaint with our office, contact Ida Saito, Operations Officer, at (541) 535-6239 3617 South Pacific Hwy Medford, OR 97501. ***You will not be penalized for filing a complaint.***