






CHANGE, INC.

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Newell, WV 26050
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200 Luray Dr.
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www.changeinc.org   

CHANGE, Inc. is an equal opportunity provider & employer.

Dear Brooke County Parent,

We are pleased to announce that this summer we will be opening the Brooke County School Based Health Center (SBHC) which will be located within Brooke High School. The SBHC will be open to all Brooke County students and their families and provides access to a Family Practice Nurse Practitioner, Licensed Clinical Social Worker and Dental Hygienist to address your medical and oral health needs. Working closely with the School Nurses, we will assure your child receives the best possible care. We understand that there are a number of barriers to care that parents face, and by having a health care center available to you Monday – Friday 7:00am to 3:00pm, our goal is to help overcome some of those barriers.

Our licensed healthcare staff can provide well check exams, sick visits, injury treatment, immunizations, allergy shots, ADHD evaluations and treatment, behavioral health, dental care, chronic health care maintenance for diabetes, seizures and asthma and to conduct sports physicals, all within the school.

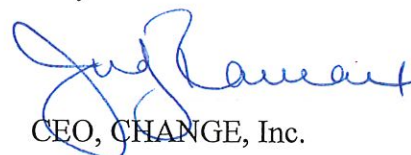
The SBHC, by no means, replaces your child's pediatrician or family provider. Our providers will assure a summary of your visit will be sent to your family provider, if requested by you, for any follow up care that is needed. If you do not have a family provider, you can easily schedule your next appointment with the staff before you leave.

We accept Medicaid, CHIP, Medicare, and all third party insurances and honor your established co-pays. We also offer a Discount Program for those families without insurance and will gladly work with you to get your family enrolled in the program.

Our goal is to have your child enrolled in the SBHC for this coming school year. We have attached the necessary forms that need to be completed, if you wish your child to utilize the medical providers at the school. *We will not be able to provide any medical services without your permission.* The forms are to gather medical history and will allow us to better serve your child. Please fill out one form per child who you have registered with the Brooke County School System.

We have attached a frequently asked questions sheet for you to review. If you have any questions, please feel free to call our main office at 304-797-7733. A direct line for the SBHC will be established closer to our summer opening. We look forward to being onsite for your family's medical needs.

Judy Raveaux



CEO, CHANGE, Inc.

Frequently Asked Questions (FAQs)

Dear Students, Parents, and Guardians,

The staff of the Brooke County School-Based Health Center is excited to assist your children with all of their health care needs. Our licensed healthcare staff is on site in a safe, child-friendly environment. We closely work with the school nurse and faculty to provide convenient care to your child. The SBHC will open June 1, 2018.

What services are available?

We'll check exams, sick visits, injury treatment, immunizations, allergy shots, ADHD evaluation and treatment, behavioral health, dental care, chronic health care maintenance--like being on site to assist with diabetes, seizures, and asthma. Just think of us as a doctor's office inside the school. We also do health education in conjunction with the teachers. You can look forward to monthly newsletters on health topics and promotion of healthy eating and exercise.

How does it work?

Parents can schedule appointments for their child before, during, or immediately after school. We welcome parents at the appointment, but a child can be seen without you present at your request. We recognize that parents work and there are transportation issues that create barriers to healthcare. We are more than happy to communicate with you via phone after seeing your child.

So for example, the school nurse calls home stating that your child came to her with an ear ache. With your permission, the nurse can bring your child right over immediately so we can evaluate to see if an infection is present. If so, we can have medication delivered to home and your child can return to class, or if your child awakens in the morning limping, you can call us or send a note to have your child's teacher send him/her down to us perhaps after lunch so they don't miss class time. School-based health centers reduce student's missed class time and parents' missed work time for health-related appointments and reduces time and costs for transportation to health-related appointments.

What dental services are offered?

We will have a dental hygienist working at our school-based health center for oral health cleanings. Our dental providers schedule weekly appointments on site to perform a range of services which include x-rays, state-required dental assessments, and applying sealants to teeth.

How does the Behavioral Health Services work?

We have individual counseling on-site provided by a licensed behavioral health specialist. A referral can be provided from the parent/guardian, our healthcare providers, your local healthcare provider, or school staff. Appointments can be made at your convenience in less than one week. Some children have chronic issues like depression or anxiety, others have lost loved ones and need grief support, and others have been through personal crises like divorce or abuse. Our specialist can also assist with management of ADHD or disruptive

behaviors such as arguing with adults and defiant behavior. An individualized plan will be developed for each situation.

What about my current doctor's office?

We encourage all families to maintain a relationship with your current doctor. We understand, however, that it isn't always convenient or possible to get your child to their office on short notice and we can help fill that gap. We will gladly correspond with your doctor after each visit. If a student does not have a current doctor, the school-based health center can serve as their medical home. CHANGE, Inc. staff provides 24 hour on-call services.

What about cost?

All children enrolled in the school-based health services program are eligible to receive service regardless of insurance status. For children insured by WV CHIP or Medicaid, the services are covered 100% (no charge). We accept most insurance plans. Our rate is the same as a physician office, which is less than urgent care and emergency room visits on most insurance co-pays. If you have no insurance, please ask our staff or call our Health Benefits Coordinator at 304-748-2828 for assistance enrolling your child in the WV CHIP program or the CHANGE, Inc. sliding fee discount program.

How do I enroll my child?

We can only provide care to your child if enrollment forms are completed. Please consider enrolling even if you are unsure if you will utilize our services. You never know when an urgent health concern will arise. You can enroll at any point during the school year if needed. Enrollment forms can be placed in your child's folder or via postal mail, or you can also stop in the office to obtain forms during health center hours, Monday - Friday 7:00AM – 3:00PM. The forms can also be downloaded from www.changeinc.org and returned to us.

We look forward to meeting you and your children. We welcome you to tour our beautiful facility, stop by and ask questions, and meet our staff. For questions, please call 304-797-7733. As we get closer to opening on June 1, 2018, a direct phone line will be assigned.

Where can I get more information?

- CHANGE, Inc. www.changeinc.org
- School-Based Health Alliance www.sbh4all.org
- Center for Health and Healthcare in Schools www.healthinschools.org

**Please complete the Enrollment Form checklist
and return to the School-Based Health Center.**

Please check one:

- My child is an active patient at a School-Based Health Center or a Family Medical Care facility.
If so, which facility? FMC Newell FMC Weirton FMC Wintersville Weirton Elementary
- I am enrolling my child at the School-Based Health Center (*Please complete the checklist below*).

If enrolling, please complete these forms found in the packet per child:

- Medical Demographics Form
- Child Informed Consent
- Medical Health History Form
- Informed Consent for Behavioral Health / Therapy
- Dental Informed Consent
- Dental History and Consent Form

Student Name: _____

Grade: _____ **Teacher:** _____

Parent/Guardian's Name: _____

Phone Number: _____

Medical Demographics Form

Patient Name: _____
Last Name *First Name* *Middle Initial*

Address: _____
Street Name *City* *State* *Zip Code*

County: _____ **Home Phone #:** _____ **Cell Phone #:** _____

Work Phone #: _____ **E-Mail:** _____

Preferred Method of Contact: Home Phone Cell Phone Work Phone Mail E-Mail

I would like to sign up to receive appointment reminders via cell phone text message: Yes No

Marital Status: M S W D **Maiden Name (if applicable):** _____ **Gender:** F M

Social Security #: _____/_____/_____ **Employed:** Full-time Part-time Student _____

Date of Birth: _____/_____/_____ **City and State of Birth:** _____

Race: _____ **Ethnicity:** Non-Hispanic Hispanic **Preferred Language:** _____

Agricultural Worker: Yes No **Veteran:** Yes No

Housing Status: Not Homeless Homeless Shelter Public Housing (Not Including Section 8)
 Transitional Other _____

Primary Care Provider: _____ **Pharmacy:** _____

Guardian Name(s) if patient is a minor: _____

Relationship to Patient: Parent Grandparent Foster Parent Other _____

Primary Contact #: _____ **Secondary Contact :** _____

(Mark all that apply to above) Emergency Contact Primary Care Giver Legal Guardian Lives With

Name of Emergency Contact: (if different than above) _____

Primary Emergency Contact #: (if different than above) _____

Child Informed Consent Form

I, _____, the parent/guardian of _____,
(Parent/Guardian's Name) (Minor's Name)
grant permission to utilize the medical, dental, and/or behavioral health services offered through the school-based health center.

Initialing each line and/or signing below, you acknowledge all of the following:

_____ **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

(Initial) In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use your Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notice of Privacy Practices" provides a more complete description of permitted uses and disclosures.

_____ **ASSIGNMENT AND RELEASE OF BENEFITS**

(Initial) I hereby authorize payment directly to CHANGE, Inc.'s Family Medical Care, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

_____ **PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES**

(Initial) I understand that the service I will be provided with via my Healthcare Provider or office staff may or may not be covered by my insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that CHANGE, Inc.'s Family Medical Care is not responsible to know whether my insurance will pay or require prior-authorization. If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reasons unpaid, as well as all efforts are made to obtain payment from my insurance, I understand I am financially responsible for payment of the denied services.

_____ **ELECTRONIC RECORD TRANSFER**

(Initial) I understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so. I understand that if I need to transfer my medical records, that I am required to sign a separate Authorization to Release form with the Medical Records department. I absolve CHANGE, Inc.'s Family Medical Care, and its personnel of any liability relating to the transfer of said records.

_____ **AUTHORIZATION TO TREAT**

(Initial) I hereby authorize any provider employed as part of CHANGE, Inc.'s Family Medical Care Health Centers, to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself.

_____ **AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION**

(Initial) I hereby authorize CHANGE, Inc.'s Family Medical Care to exchange health and education records (including immunization records) with the appropriate school district for the purpose of providing care and treatment, if applicable.

HIPAA RELEASE: I hereby authorize CHANGE, Inc.'s Family Medical Care Health Centers, providers and/or staff to discuss my medical information with the following person(s); This does not allow the release of records to this person(s):

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Patient's/Guardian's Signature

Date

Relationship to Patient

Medical Health History Form

Patient's Name: _____ Birth Date: ____/____/____

Patient's Family Doctor: _____ Phone: (____)____-____

Eye glasses? No Yes

Exposed to second hand smoke? No Yes

List Medications taken on a daily basis:

Name: _____ mg _____ Frequency: _____

Name: _____ mg _____ Frequency: _____

Name: _____ mg _____ Frequency: _____

Please list any Chronic Health Problems, Previous Hospitalization, or Surgery: _____

Allergies (If yes, please list):

Food: No Yes If yes, _____

Medication: No Yes If yes, _____

Bees: No Yes If yes, _____

Any history of or difficulty with any of the following? (check if yes):

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drugs/Alcohol | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bleeding, Excessive | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Urinary Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles | <input type="checkbox"/> Other: _____ |

Date of last Well Child Visit: _____

The information that I have provided is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status.

Parent/Guardian Signature: _____

Date: _____

All Information is confidential.

Date: _____
 Patient's Full Name: _____ Grade: _____ Sex: _____
 Birth Date: ____/____/____ Social Security #: ____/____/____ Race: _____

I authorize a physician assistant, physician, or designated health professional to provide necessary and/or advisable treatment for my child. I authorize release of written and verbal information relevant to my child's health care between the school nurse and the health center's staff only when necessary for his/her care. In case of emergency, every effort will be made by the health center staff to notify the parent/guardian. I understand the acknowledgement of Notice of Privacy Practices and know my minor child's rights as a patient of the school-based health center.

I authorize the school-based health center to release information regarding treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the CHANGE, Inc.'s Family Medical Care. I am financially responsible for non-covered services, but understand that services will not be denied due to inability to pay.

Guarantor Insurance:

Mother/Guardian: _____ Birth Date: ____/____/____
 Mother's SSN: ____/____/____ Work #: (____)____-____ Cell #: (____)____-____

Father/Guardian: _____ Birth Date: ____/____/____
 Father's SSN: ____/____/____ Work #: (____)____-____ Cell #: (____)____-____

Patient's Home Address: _____ City: _____ State: _____ Zip: _____
 Patient's Home Phone #: (____)____-____
 Guardian's Email Address: _____

Name of Emergency Contact in case parent cannot be reached: _____
 Relationship to Patient: _____ Phone #: (____)____-____

Parent/Guardian Signature: _____ **Date:** _____

Insurance Information: Please send a copy of the insurance/medical card (if possible).

Private Insurance

Name of Insurance Company: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: (____)____-____ Employer/Company Name: _____
 Name of Insured Employee: _____ Birth Date: ____/____/____ SSN: ____/____/____
 Policy Number: _____ Group Number: _____

MEDICAID

ID NUMBER

- | | |
|---|-----------------------|
| 1. <input type="checkbox"/> Straight West Virginia Medicaid | _____ |
| 2. <input type="checkbox"/> Aetna Better Health | _____ |
| 3. <input type="checkbox"/> Health Plan | _____ |
| 4. <input type="checkbox"/> Unicare | _____ |
| 5. <input type="checkbox"/> WV Family Health Plan | _____ |
| 6. <input type="checkbox"/> WV CHIP | _____ Co-Pay \$ _____ |
| 7. <input type="checkbox"/> Straight Ohio Medicaid | _____ |
| 8. <input type="checkbox"/> Buckeye Community Health Plan | _____ |
| 9. <input type="checkbox"/> CareSource of Ohio | _____ |
| 10. <input type="checkbox"/> Molina of Ohio | _____ |
| 11. <input type="checkbox"/> Paramount | _____ |
| 12. <input type="checkbox"/> United Healthcare of Ohio | _____ |

No Insurance / Private Pay (A sliding fee scale is available for families that are uninsured. Charges are based on income and family size. A copy of the parent/guardian's proof of income must be on file with the application in order to be eligible). **Please call our health benefits coordinator at 304-748-2828 or 740-314-8258.**

INFORMED CONSENT FOR BEHAVIORAL HEALTH/THERAPY

This form documents that we, _____ (“parents/guardian”), give our consent and agreement to _____ (“therapist”) to provide therapeutic treatment to, _____ (“patient”) and to include us, the parents, as necessary, in regards to the treatment.

While the parents can expect benefits from this treatment, they fully understand that no particular outcome can be guaranteed. The parents understand that they are free to discontinue treatment at any time, but that it would be best to discuss with the therapist any plans to end therapy before doing so.

The parents have fully discussed with the therapist what is involved in therapy and understand and agree to the policies about scheduling, fees and missed appointments. The discussion about therapy has included the therapist’s evaluation of present problems, the method of treatment, goals and length of treatment, and information about record-keeping. The parents have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. The parents understand that therapy can sometimes cause upsetting feelings to emerge, and that problems may worsen temporarily before improving.

The therapist has told the parents whom to call if an emergency arises if the therapist is unavailable. Failure to follow through with therapist emergency recommendations may result in termination of services.

The parents have access to a copy of this form and a HIPAA Notice of Privacy Practices. A copy can be provided if the parents do not have access to the internet. The parents understand that information about therapy is almost always kept confidential by the therapist and not revealed to others besides the parents unless a parent authorizes such release. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The therapist is required by law to report suspected child abuse or neglect to the proper authorities.
2. If the therapist learns that he or she intends to harm another person, the therapist must try to protect the endangered person, including by telling the police, the person and other health care providers. Similarly, if self-harm is disclosed or health is in any immediate danger, the therapist will try to protect, including, as necessary, by telling the police and other health care providers, who may be able to assist.
3. If court proceedings are involved, the therapist may be required by law to reveal information about treatment. These situations include child custody disputes, cases where a patient’s psychological condition is an issue, lawsuits or formal complaints against the therapist, civil commitment hearings, and court-ordered treatment.
4. If health insurance or managed care plan will be reimbursing or paying the therapist directly, they will require that confidentiality be waived and that the therapist give them information about the treatment.
5. The therapist may consult with other healthcare professionals about treatment, but in doing so, will not reveal any personal, identifiable information unless specific consent to do so is obtained from a parent. Further, when the therapist is away or unavailable, another therapist may answer calls and will need to have access to information about the treatment.
6. If an account with the therapist becomes overdue and responsible parties do not work out a payment plan, the therapist will have to reveal a limited amount of information about a patient’s treatment in taking legal measures to be paid. This would include the names, social security number, address, dates and type of treatment and the amount due.

In all the situations described above, the therapist will try to discuss the situation with a parent before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

The parents/legal guardians have rights to general information about the therapy such progress, information about any dangers present (self or others), and, upon request, copies of the treatment records (with certain qualifications and exceptions). The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust

between patient and therapist, especially for adolescents over the age of 12.

The parents agree that in the event of custody or visitation hearings regarding any legal proceedings, each of the parents and their attorneys will not require the therapist to testify as any such action could interfere with the treatment provided. If such a proceeding does occur, a mental health professional will be appointed to perform such an evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding. Written information regarding, and/or the record of treatment will only be provided as required by law or upon the authorization of either parent.

Children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the therapist. If both parents are consenting to therapy:

- Each of us agrees that he or she will not end the therapy without the agreement of the other parent, and that if we disagree about the continuation of therapy, we will try to come to an agreement, by counseling if necessary, before ending therapy.
- We each agree to cooperate with the treatment plan. We understand that without mutual cooperation, the therapist may not be able to act in the best interests and may have to end therapy.
- We agree that each of us has, and shall continue to have, the right to be informed about the progress of treatment and have access to the treatment records of the therapist. We further agree that the therapist may release information or records to either of us without any additional authorization of the other.

If participating in a managed care plan, the parents have discussed with the therapist their financial responsibility for co-payments and the plan's limits on the number of therapy sessions. If the parents are not participating in a managed care program, they understand that they are fully, financially responsible for treatment including any portion of the fees not reimbursed by health insurance. The therapist has also discussed options for continuation of treatment when managed care or health insurance benefits end. If uninsured, the parent will be informed of the sliding fee scale discount program available through CHANGE, Inc.

The parents understand that they have a right to ask the therapist about the therapist's training and qualifications and about where to file complaints about the therapist's professional conduct.

By signing below, the parents/legal guardians are indicating that they have read and understood this agreement, that they give consent to the therapist's treatment, and that they have the proper legal status to give consent for therapy.

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

Date

Signature of Patient (over 12 Years of Age)

Date

DENTAL INFORMED CONSENT

Patient's Name: _____

The form is to obtain your consent for dental treatment. Please read this form carefully and ask us about anything that you do not understand. Our dentist, dental hygienist, or the dental staff will be pleased to explain it. Thank you.

Below is a list of dental procedures that may be performed on your child:

1. **Diagnostic Procedures:** Radiographs (X-rays), photographs of the teeth and jaws, and Caries Risk Assessment.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth using hand instruments and ultra-sonic scalers, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay. No eating or drinking thirty minutes after application.
4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. **Local Anesthesia:** Anesthesia is administered prior to a procedure to help dull pain. The most common form is local anesthesia, meaning that it dulls pain in all or part of the mouth during dental work, but does not cause the patient to go to sleep. It usually wears off two to three hours after the procedure and is most often used when a patient is getting a filling or extraction.
6. **Fillings and Repairs:** Dental fillings and repairs use restorative materials used to repair teeth which have been compromised due to cavities or trauma. A filling helps to restore a tooth damaged by decay back to its normal function and shape, and helps prevent further decay by eliminating areas where bacteria can enter the tooth. Your dentist will consider a number of factors when choose which type of filing material is best for the patient.
7. **Extractions:** A severely damaged tooth may need to be extracted.

Please note that additional procedures may need to be completed by a pediatric dentist.

I understand that all dental procedures have associated risks and I acknowledge giving my consent for treatment listed above.

(Patient or Parent/Guardian's Signature)

Date

Dental History and Consent Form

General Information

Patient's Name: _____ Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian: _____ Email: _____

Home Phone: _____ Cell Phone: _____

School: _____ Grade: _____ Teacher's Name: _____

Sex: Male Female Race/Ethnicity (*Check all that apply*): American Indian/Alaskan Native Caucasian
 African American Asian Hispanic/Latino Native Hawaiian/Pacific Islander

Health & Dental Information

Patient's Physician: _____ Patient's Dentist: _____

Is a serious health problem present? Yes No

If yes, please explain: _____

Asthma? Yes No

History of rheumatic fever or rheumatic heart disease? Yes No

Are antibiotics required before dental care? Yes No

Currently taking any medications? Yes No

If yes, please list: _____

Allergic to any medication? Yes No

If yes, please list: _____

Allergic to latex? Yes No

Date of last dental exam: _____

What was the reason for the visit? _____

During the last 12 months, was there any time dental care was needed, but unable to receive dental services?
 Yes No

If yes, why (check all that apply)?

- | | | |
|--|---|---|
| <input type="checkbox"/> Could not afford it. | <input type="checkbox"/> Not serious enough problem. | <input type="checkbox"/> No insurance. |
| <input type="checkbox"/> No transportation. | <input type="checkbox"/> Difficulty getting an appointment. | <input type="checkbox"/> Do not have a dentist. |
| <input type="checkbox"/> Dentist did not take Medicaid/Insurance | <input type="checkbox"/> Do not know/Do not remember. | <input type="checkbox"/> Other: |

(over...)

Dental History and Consent Form *(continued)*

Payment Information

Please provide the following billing information along with a copy of your insurance card:

MEDICAID/CHIP

Patient's Name: _____

Policy Holder ID # / SSN: _____ Plan/Group #: _____

DENTAL INSURANCE

Name of Insurance Company: _____

Address of Insurance Company: _____

Name of Policy Holder: _____

Policy Holder ID # / SSN: _____ Plan/Group #: _____

Employer Name: _____

Consent for Treatment and Billing: Signature Required

In general, any information that is about your health, the care and treatment you receive or the payment for care and treatment is considered protected health information (PHI) and protected by the School-Based Health Center Program.

Your signature below gives permission for the School-Based Health Center, a division of CHANGE, Inc., to share the results of the dental exam with the appropriate State Health and Human Resources and the State Department of Education.

Your signature below indicates that you are the parent or legal guardian of the patient whose name appears on the application. By signing below, you understand that participating in the program is voluntary and hereby agree to release and discharge all parties involved, including without limitation the dental professionals who are conducting the examinations or screenings, from any and all liabilities, suits, costs or expenses in any way relating to the treatment provided.

Your signature below indicates that you are the patient's parent or legal guardian and give consent for dental examination or screening, cleaning, fluoride, sealants, x-rays, and any necessary dental procedures to correct the dental and oral defects as prescribed.

Signature of Parent/Guardian: _____ **Date:** _____