(Place patient label here if blank, or handwrite Name, DOB, & MRN)

Akron Children's

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES MULTI-DISCIPLINARY CONSENT FORM

SCHOOL-BASED HEALTH CENTER SERVICES

Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians". The use of the term "me" "myself" or "my" shall refer to the student. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

I and/or my parent(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or designees, do all things that may be needed to diagnose, treat and care for the needs of the above-referenced student. Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care. I understand and agree that Children's pharmacists may be utilized in the management of my care pursuant to a consult agreement between the pharmacist and my health care provider. I understand and acknowledge that I may elect not to participate in the consult agreement by notifying Children's in writing as set forth at the end of this consent. I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, internal education purposes, legal purposes and quality improvement purposes. I understand and agree that Children's may at its discretion provide certain services to me by remote means called "telehealth". I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians, or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians, and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or Judgements. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PATIENT RIGHTS/PRIVACY INFORMATION: I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

Patient Rights and Responsibilities	Advance Directive Information (Patients 18 years and older)
Complaint/Grievance Procedure	Free Hospital Care Information
Health Information Exchange	"An Important Message from Medicare" (Medicare patients)
Brochure HIPAA Notice of Privacy Practices	"An Important Message trom Tricare" (Tricare patients)

AUTHORIZATION TO COMMUNICATE: I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text message, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback, and communicating/discussing financial responsibilities. By signing this form, I am granting permission to Children's and its affiliates, clinical providers, and business associates, including any billing services, collection agencies, agents or third parties who may act on Children's behalf, to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email, or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID: I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

PrivacyPractices
Children's Notice of Privacy Practices is available upon request at any School District building where services are provided. You can also view the Notice of Privacy Practices online at https://www.akronchildrens.org/pages/Prlvacy-Policy.html. Children's Notice of Privacy Practices describes how Children's may use and disclose you/your child's health information and how you can access you/your child's health information. Information regarding the services provided to you/your child may be shared with School District nurses, counselors, and social workers involved in your/your child's care and with your/your child's health care providers for treatment purposes. Except as provided above and in Children's Notice of Privacy Practices, Children's will not disclose your/your child's health information without your written authorization.

TERMS AND CONDITIONS FOR TREATMENT VIA TELEMEDICINE:
I acknowledge and understand that if this visit will be conducted by telemedicine:

- The provider will evaluate me or my child and recommend any tests and treatments based on their assessment.
- If the provider is unable to fully evaluate me or my child using a telehealth visit, they may recommend follow-up in the office or other care setting.
- Our session is not being video recorded.
- Every effort will be made to protect personal health information.
- I or my insurance may be billed for this visit. This visit may not be covered through my current insurance plan or government program (excluding Medicaid). If it is not covered by my insurance, I may be responsible for the cost.

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Akron Children's

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES MULTI-DISCIPLINARY CONSENT FORM

School Name:

PLEASE COMPLETE ALL OF THE INFORMATION BELOW- Please print using ink (incomplete forms will not be accepted)

FIRST NAME (of student)		LAST NAME (of student)	
Gender: Male Female (assigned at birth)	Birthdate: (mo/day/yr)	Age	Grade
Preferred Pronouns: (he/she/they)	Preferred Language:	Address	
Home Phone #	Cell Phone #	City / State / Zip Code	
Do you have a primary doctor? ☐ YES (list below) ☐ NO Doctor's Name: Phone #:		Pharmacy Name: Address:	

PARENT/GUARDIAN INFORMATION

First Name:	Last Name:	Phone #:	Relationship to Student:

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPRIATE BOX)

Insurance Name:	
Insurance Address:	
Subscriber Name/ID #	Subscriber DOB:
MMIS:	Group #:

☐ NONE, please connect me to Children's Financial Counselor

All services provided are billed to insurance. If you do not have insurance, Children's will connect you to financial assistance. No child is denied services for inability to pay.

STUDENT HEALTH HISTORY

Allergies: ☐ YES (list below) ☐ NO

Medications: ☐ YES (list below) ☐ NO

Other medical problems/health concerns: ☐ YES (list below) ☐ NO

CONSENT FOR SCHOOL BASED HEALTH CENTER SERVICES

I have read this consent form or have had it read to me, and it has been explained to my satisfaction. This consent is valid until the student is no longer enrolled in the School or until revoked by me in writing to Children's. To revoke your consent, submit your revocation in writing to the Privacy Officer at Akron Children's Hospital, One Perkins Square, Akron, Ohio 44308.

By signing below, I acknowledge that I understand and accept the terms of this consent and confirm that I have legal ability to consent for the treatment. I agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In some situations Ohio law permits a minor to consent to medical care without parental consent. For example, parental consent is not required for contraception, pregnancy testing, and prenatal care; sexually transmitted disease testing and diagnosis; HIV testing; treatment of drug and alcohol related conditions; and certain outpatient mental health services. Further, parental consent is not required for the application of first aid treatment or in an emergency.

PLEASE CHECK THE BOX(ES) FOR THE SERVICES BEING REQUESTED:

☐ School Based Health Medical Services ☐ School Based Asthma Therapy Program ☐ School Based Behavioral Health

Time Period During Which Consent is Authorized:

From: Date that form is signed on opposite page

To: Date that student is no longer enrolled in the School

Printed Name of Parent/Legal Guardian	Date of Birth	Signature of Parent/Legal Guardian	Date	Time
Printed Name of Witness #1 to Signature if Verbal Consent *(health care personnel only)*		Signature of Witness #1	Date	Time
Printed Name of Witness #2 to Signature if Verbal Consent *(health care personnel only)*		Signature of Witness #2	Date	Time

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