Laurel Health School Based Mobile Health Center

Consent for Treatment, Payment and Health Care Operations (TPO)

Students Name: **Date of birth:** **Medical Record Number:**

Students Current School: **Students Current Grade:**

Consent for Routine Care and Treatment

I, __________________________ **(print name)** on behalf of ____________________________ (patient name and relationship) authorize Laurel Health School Based Health Center (SBHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgement of Laurel Health medical personnel, is deemed necessary or advisable in my child's care. This may include all routine diagnostic point of care tests, testing and treatment of sexually transmitted diseases, pregnancy testing, vision and hearing screenings and the administration of medications. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by Laurel Health personnel.

I understand I may be contacted by Laurel Health or representative by cellular phone, which may include the use of pre-recorded/artificial voice messages, and/or an automated dialing device ("auto dialer") or by text message or e-mail in connection with any communication made to me or related to my accounts. **______ Patient Initials (required)**

Beneficiary Agreement.

I have been notified that my insurance company may deny payment for some service. If my insurance company denies payment, I agree to personally be responsible for payment.

______ Patient Initials (required)

Payment & Collection Policy.

It is the parents or guardian's responsibility to provide the Laurel Health SBHC with accurate information regarding current address, health insurance, and applicable financial resources to determine whether the patient is eligible for coverage through existing private insurance, available public assistance programs or the Laurel Health Center Sliding fee program.

Payment is expected upon receipt of the first statement or in accordance with a mutually agreed upon payment agreement. If payment cannot be made in full upon receipt of the first statement, a payment agreement is necessary. It is the patient's responsibility to request an agreement.

The following methods of payment are acceptable:

1. Cash
2. Check
3. Money Order

4. Visa/MasterCard/Discover Credit and Debit Cards

Accounts with no payments following two statements will be turned over to a collection agency following review of the account. Collection agencies may determine that an account is eligible for legal action if it is determined that income/assets are available to the guarantor to meet their financial obligations on the account.
If turned over to a collection agency, future appointments may be limited to emergency visits only until payment arrangements are made.
If you have questions or concerns regarding your account, please call the Laurel Health Center Billing Office at 1-833-LAURELHC (528-7354)

______ **Patient Initials (required)**

Consent to Release Information.

I authorize Laurel Health SBHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my heath care treatment: (2) to enable Laurel Health Centers to obtain payment for the services provided to me; and (3) to permit Laurel Health Centers to carry out ordinary health care and business operations such as quality assurance, service planning and general administration. I am aware that Laurel Health SBHC may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

______ **Patient Initials (required)**

After Hours Coverage.

For after-hours emergencies, including evenings and weekends, a physician is available on call 24 hours a day. Just dial 1-844-284-6589.

Meeting Your Concerns.

Communication between the patient and our Laurel Health SBHC team is an important element of good health care. If you have concerns about any aspect of your health care, we ask that you first discuss the problem directly with your nurse or provider. If you are
not satisfied, please contact the Laurel Health Center Administration Office at 1-833-LAURELHC (528-7354). If you remain dissatisfied, you may also call the Pennsylvania Department of Health Hotline for Complaints at 1-800-254-5164, or write to the Pennsylvania Department of Health, Division of Acute and Ambulatory Care, 625 Forester Street, Room 532, Health and Welfare Building, Harrisburg PA. 17120.

Confidential Demographic Information (Optional).

Laurel Health Centers receives federal grant funding to support our services. Annually we are asked to provide reporting on demographic, clinical, operational, and financial data. Your assistance in gathering this information will help us apply for future grant funding. All information provided is completely confidential and we thank you for your cooperation.

Acknowledgement of Receipt of Notice of Privacy Policies, Patient Rights/ Responsibilities Policy/ Patient Non-Discrimination Policy.

I acknowledge that I have been provided a copy of the Laurel Health Centers Notice of Privacy Policies, which describes how health information about me may be disclosed by Laurel Health Centers and how I may obtain access to and control the use and disclosure of this information. I have also received notice of the Patients' Rights and Responsibilities Policy. I understand my rights and responsibilities. I have also received notice of the Patient Non-Discrimination Policy. I agree to participate actively in my care in accordance with these rights and responsibilities.

______ Patient Initials (required)

I have read this Consent for Treatment, Payment and Health Care Operations form for school-based care or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form is valid for one (1) year from the date that I sign it and applies to Laurel Health School Based Health Care only. For outpatient behavioral health services and Laurel Health Center services, a separate consent is required for an encounter.

___ Yes, I consent for my child to receive medical care at the School Based Mobile Health Center.

___ No, I do not wish for my child to receive medical care at the School Based Mobile Health Center.

Patient Signature	Date	Time	Signature of LHSBHC Representative
Signature/Identity on behalf of patient/ Relationship Name	Date	Time	Signature of LHSBHC Representative

Legal Guardian Name:	Address	Phone Number
Legal Guardian Name:	Address	Phone Number

Insurance Company:	Policy ID # & Group #:
Subscriber Name/Date of Birth:	Patient Relationship to Subscriber: __ Self __Spouse __Child __ Other

We are a Federally Qualified Health Center (FQHC) and so are covered by the Federal Tort Claims Act (FTCA), meaning all malpractice claims are subject to federal procedural law. This health center receives funding from the United States Department of Health and Human Services (HHS) and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. For more information, see bphc.hrsa.gov/ftca