Informed Consent: Shortridge School-Based Health Clinic Services provided by Raphael Health Center, Inc.

I give permission for (student's full name) _____ to receive health services from Raphael Health Center's (RHC) school-based clinic at Shortridge High School. I understand that the RHC school-based clinic provider does not replace my child's Primary Care Provider and cannot take care of all my child's health care needs.

1. Consent: I have read the information provided regarding the RHC school-based health clinic and the release of information and I understand what services the school-based clinic will and will not provide. My consent will allow my child to receive health services while he/she is a student at this school. I understand that if I choose to cancel these services, I must provide the request in writing. It will be my responsibility to notify the RHC clinic staff regarding changes in guardianship, contact information and health history.

2. Information Privacy: I have been informed that Raphael Health Center has prepared a detailed NOTICE OF PRIVACY PRACTICES regarding my child's personal health information. I understand that the terms of the notice may change, and current notices will be available on RHC's website and at RHC facilities.

3. Release of Information: I understand the services provided by the school-based health care clinic are confidential. The RHC clinic will use and disclose my child's personal health information to provide treatment and for improvement of healthcare operations. My child's information may be shared with my child's physician/provider, appropriate school staff, or with my child's insurance provider for legitimate purposes. I authorize the release of my child's medical information to other providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation. In addition, I give my consent to the clinic staff to look at my child's school health record, including immunizations.

INSURANCE RELEASE/PATIENT RESPONSIBILITY:
• I hereby authorize Raphael Health Center to apply for benefits on my behalf for services rendered to me by Raphael Health Center providers or by their orders. • I request that payment of authorized insurance benefits be made on my behalf to Raphael Health Center for any services provided to me. I authorize any holder of medical information about me, to release, to the insurance company any information needed to determine these benefits or the benefits payable for related services. • I hereby authorize this office to release any information acquired to establish a health insurance claim. I authorize this office to obtain previous medical records from other physicians and/or medical facilities, including but not limited to information regarding treatment of drug or alcohol abuse, psychological conditions, hiv testing or an aids related condition. • I understand that i may be personally responsible for all charges including deductibles, co-pays, non covered services and any amount not covered by my insurance (except in cases of a contractual agreement between my insurance carrier and Raphael health center). I understand that the charges i am responsible for are to be paid at the time of service.
☐ **Hoosier Healthwise/Medicaid #:**
☐ **Private Insurance Company Name:** **Member #:** **Group #:**
(*Information for Families who do not have health coverage):* **Family's Total Gross Income before taxes:** _____ ☐ **Per week** ☐ **Bi-weekly** ☐ **Monthly** ☐ **Yearly** **Does your student qualify for the free/reduced lunch program?** ☐ **Yes** ☐ **No**

REQUIRED SIGNATURES/ACKNOWLEDGEMENT:

Parent/Guardian Signature (required):
_____ **(Parent's initials) I acknowledge that I have received a copy of the Raphael Health Center NOTICE OF PRIVACY PRACTICES**. *SERVICES WILL NOT BE PROVIDED WITHOUT PARENTAL CONSENT AS REQUIRED BY THE INDIANA STATE LAW.*
Emergency Contact: **Phone #:**
Hospital Preference:
Additional notifications: **Parent/Guardian (s):** **Phone #:**