Dear Parent or Guardian,

Bluegrass Community Health Center - Clark County School Clinic is a unique opportunity for Clark County. It offers the students and community members access to medical care when it might otherwise not be available. We operate year-round even when school is not in session. We work with school nurses, teachers, parents, and your child's previous and current providers to deliver medical care, behavioral health, and resource coordination services. We offer services to students regardless of insurance status or ability to pay. When available, insurance will be billed. The health center may release information regarding treatment to third party payors for billing purposes. Please complete the registration packet included to apply for discounted services.

Students must have their parent's written permission to receive services that include treating illness, providing urgent care, and helping students manage chronic conditions through the Clark County School Clinic. Parents/ Guardians are always welcome at the appointments but are not required to be there. Confidentiality between the student, parents, and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

Please complete and sign the attached form and return it to the school with your student. We look forward to working with you and your child this year. Parents are welcome to contact Bluegrass Community Health Center with concerns so that we can work together to provide the best care for each student. We are always open to questions/concerns and welcome your feedback.

Sincerely,

Alan S. Wrightson, MD
Chief Executive Officer
Bluegrass Community Health Center

Bluegrass Community Health Center

Clark County School Clinic

WAIVER FORM

Student Name: _____ Birth date: _____

CONSENT FOR CCSC (Clark County School Clinic) SERVICES

I am the legal guardian of the above-named child. I am giving consent for this child to be treated in my absence by Bluegrass Community Health Center – Clark County School Clinic. Crisis interventions and emergency care do not require consent. In emergent situations, life-saving interventions will be initiated without prior consent.

My child may be treated by Bluegrass Community Health Center for the following:

Initial the type of service you wish your child to receive.

_____**ALL HEALTH SERVICES** - I give consent for Bluegrass Community Health Center - Clark County School Clinic to provide my child with medical and behavioral health evaluation and treatment, including labs, medications, telehealth, wellness visits, and vaccines.

_____**ALL HEALTH SERVICES EXCEPT VACCINES** -I do NOT wish for my child to receive vaccines at the school clinic.

_____**NO HEALTH SERVICES** - I do NOT wish for my child to receive ANY medical services at the school-based clinic.

_____ _____

Signature of Parent / Legal Guardian Date

_____

Print Parent / Legal Guardian Name

Emergency Contact Information

Father	Home Number	Work Number	Cellphone Number	Email
Mother	Phone Number	Work Number	Cellphone Number	Email
Guardian	Phone Number	Work Number	Cellphone Number	Email
Alternate	Phone Number	Work Number	Cellphone Number	Email

Bluegrass Community Health Center

Clark County School Clinic

Patient First Name	Last Name	Middle	Patient Date of Birth:

My signature below attests that I am the ☐ **Patient** or I am the ☐ **Biological/Adoptive Parent** ☐ **Legal Guardian; or** ☐ **Foster Parent** for the patient named above and my agreement of the below terms.

AGREEMENT OF CHARGES

I acknowledge responsibility for all charges incurred by me (or any person for whom I am responsible) for services rendered. I agree to pay you regular charges for clinical services rendered.

If I am covered by an insurance plan that is accepted at Bluegrass Community Health Center, my insurance company will be billed. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of benefits directly to BCHC. My health insurance may pay all or part of BCHC's fees. I agree to pay the balance of those charges which are not paid by my health insurance.

If I am uninsured, I will be provided a complete accounting of all charges and I am responsible for such charges at the time of service. I understand that I must pay for contraception, 3rd party labs, optional procedures and immunizations before those orders are performed.

I will submit a verification of household income at or before my initial visit and each year thereafter if I wish to apply for discounts. I will inform BCHC of any changes in my household income and/or household members as this information will be used to determine the amount I pay.

CONSENT TO TREAT

I hereby voluntarily consent to outpatient care including routine and diagnostic procedures. As part of the medical procedures or tests, I may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease when such test is ordered by my provider for diagnostic purposes and vaccines. Additionally, adults and adolescents are routinely screened for psychiatric needs, reproductive health, and substance use as part of holistic patient care. Screening results and treatment options for psychiatric symptoms and substance use will be shared with parent(s)/guardian(s) of adolescent patients at the provider's discretion.

I hereby authorize the release of information acquired in the course of my registration, examination, or treatment to the Bluegrass Community Health Center staff, as well as to other health care providers, for the purpose of continuing care. For example, because medical and behavioral health services are integrated at BCHC, I understand that my medical provider may share information with my behavioral health provider and vice versa in order to maximize my treatment. Furthermore, if I am referred to an outside provider for specialty care or other service, I understand that the relevant portion of my medical record will be sent to the referral provider in order to coordinate care.

NOTICE OF PRIVACY PRACTICES

I have received a Notice of Privacy Practices from Bluegrass Community Health Center that informed me of my rights regarding how my health care provider may use and disclose my protected health information and Bluegrass Community Health Center's legal duties and privacy practices with respect to protected health information.

By signing this form, I acknowledge receipt of this information and agree to the terms.

_____ _____

Patient or Parent/Legal Guardian Signature **Date**

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fax (859) 254-7874