# Consent for Vision Services
## School-Based Health Center
## Cincinnati Health Department

**PLEASE SIGN ALL PAGES.**

**Patient's (student's) Name:** ___________________________________________ **DOB:** _____________ **Sex:** **M or F**

**Patient's Social Security # (if known)** _______________**Insurance Provider:** _________________ **Ins. #:** _________________

Please **Check YES** in each section to agree to those services for the student listed above:

**VISION SERVICES:**

__ **YES,** I consent for my student to receive **VISION SERVICES** at the OneSight Vision Center at Oyler which may include comprehensive eye exams including dilation, vision therapy, and the fitting and dispensing of vision correction. (*note: the Vision Center will open for service in the fall of 2012)

__ **NO,** I do not wish for my student to receive **VISION SERVICES** at the OneSight Vision Center at Oyler

**TRANSPORTATION:**

__ **YES,** I consent for my student to be **TRANSPORTED/ ACCOMPANIED** to and from the OneSight Vision Center at Oyler by a representative of the school or Urban Appalachian Council if I cannot be contacted and/or cannot accompany my student.

***By checking yes I release from liability associated with this event the officers, directors, employees, Cincinnati Public Schools, and the Urban Appalachian Council.***

__ **NO,** I do not wish for my student to be transported to or from school for these purposes.

By signing this consent, I agree to the terms and conditions regarding the **PAYMENT FOR SERVICES** and **SHARING OF HEALTH INFORMATION** as explained in the accompanying **Program Description** form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have received the **Notice of Privacy Practices** which is attached separately.

_______________________________________ _______________________________________

**Parent/Guardian Signature** **Date** **Parent/Guardian's Printed Name**

_______________________________________ _______________________________________

**Patient's Signature** (if 18 or older) **Date** **Patient's (Student's) Printed Name**

**(Please continue to the next page)**

Student Information

School-Based Health Center

*In order to provide health services for your student we need the following information:*

**Name of Parent/Guardian: ___________________________________Parent/Guardian's Date of Birth: ____________**

**Relationship to Student: ____________________ Parent/Guardian's Social Security No.: ______________________**

**Address: ________________________________________________________________________________**

| Student's Name | Date of Birth | Insurance Provider Name | Insurance Number |
|---|---|---|---|
| | | □ Amerigroup □ Caresource<br>□ Molina □ Other_______ | |

**Home Phone: _______________________Cell Phone: _______________________Work Phone: _________________**

**Emergency Contact Person: __________________________________________ Phone Number: __________________**

Student/Adolescent's Regular Medical Doctor or Health Center: ______________________________________________

Address ________________________________Phone #: _______________Date of last full examination: _____________

Is your student being treated for any condition now? YES or NO. If yes, please list: ___________________________

_____________________________________________________________________________________________

Please list any medications your student takes: _____________________________________________________________

1. **Is your student allergic to any medications?**

   No___________ Yes_______________ Please list: ____________________________________________

2. **Any food allergies?** Please list _________________________________________________________________

3. **Any other allergies?** Please list ________________________________________________________________

4. **Did your student have any of these problems?**

   Prematurity or birth weight under 5 lbs.______________ Difficult delivery____________________________________

   Poor growth/slow development in infancy ____________ Drugs/ alcohol used during pregnancy _________________

<u>School, Vision and Health Concerns</u>

Does your student have any learning problems? YES NO

Has your student worn glasses before YES NO

Does your student get into trouble at school? YES NO

Does your student have trouble reading? YES NO

Do student's eyes itch or rub frequently? YES NO

Does your student have headaches? YES NO

Check if your **student** has or has had the following:

_____ Diabetes /weight loss or gain
_____ Urine/Bowel problems
_____ Breathing/wheezing trouble
_____ Eye disease (lazy eye, glaucoma, etc)
_____ Eye surgery
_____ Heart disease
_____ Recent fever/chills
_____ Very nervous or sad
_____ Bone, muscle or joint pain
_____ Stomach/digestive trouble
_____ High blood pressure
_____ Sickle Cell
_____ Seizures
_____ History of cancer
_____ Skin or hair problems

Explain: __________________ ______________________________________________________________________

Has anyone in the **family** had the following?

__________ Heart disease/hypertension ________ Eye problems or disease ________ Diabetes

Explain: ________________________________________________________________________________________

**Parent/Guardian Signature __________________________________________ Date of Signature______________**

**Thank you for your time used in completing your student health history and consent form.**

# THE FOLLOWING PAGES ARE FOR YOU TO REVIEW AND KEEP FOR YOUR RECORDS

**Program Description**
**School-Based Health Center**
**Cincinnati Health Department**

**Regarding PAYMENT FOR SERVICES:**

- If you do not have health insurance for your student, you will be responsible for the bill at the appropriate **discounted fee**. However, no student will be denied care due to inability to pay for services.
- If you do not have health insurance for your student, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at the CHD. If your insurance does not cover CHD, you will be responsible for the bill at the appropriate discounted fee based on your household income.
- No student will be denied care due to inability to pay for services.
- **We can help you if you need assistance applying for Medicaid**, you can stop by our center or call 513-357-2809. You can also contact Urban Appalachian Council at 251-0202 or the Hamilton County Job and Family Services Department at 946-1000.

**Regarding the SHARING OF HEALTH INFORMATION:**

- The School-Based Health Center may request medical records/information from any health care provider or facility where your student has been seen.
- Results of the visit will be sent by the School-Based Health Center to your student's regular doctor/health center.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The student's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your student's information will be kept strictly confidential according to all state and federal laws.

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**Patient Consent for Use and Disclosure**
**of Protected Health Information**

With my consent, School-Based Health Center or the CHD may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cincinnati Health Department's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Cincinnati Health Department reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Price Hill Health Center at 2136 W. Eighth Street, Cincinnati, OH 45204.

With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or CHD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or CHD restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, School-Based Health Center may decline to provide treatment to me.

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*Please note that the **School-Based Health Center** is completely **optional. School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.**

**This consent will remain in effect until your student is no longer enrolled in Cincinnati Public Schools.** You **may revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your student removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

**Please keep this Program Description for your records.**

**The School-Based Health Center** is an excellent way to keep your student healthy and in school. **Please let us know if there is anything keeping you from enrolling your student.** If you have any questions or need help with the application, **please call the School Health Program 357-2809 or contact your school nurse.**