CONSENT TO RECEIVE SERVICES PROVIDED BY THE SCHOOL-BASED HEALTH CENTER
Pendleton Community Care in Pendleton County Schools
School Year 2009/10; expires October 1, 2010

Student's Name: _____
First MI Last

Date of Birth: _____ **Gender: (Circle one) Female Male**

Student's Social Security Number: _____

*****Student Allergies, including typical reaction:** _____

_____

Parent's Work Phone: _____ **Home Phone:** _____

Mailing Address: _____
Rte or Box Number Town State Zip

Financial Information: □ **Private Pay** □ **PEIA #** _____

□ **Medicaid #** _____ □ **CHIPS** _____

□ **Parent's Insurance Company/#** _____
Covered employee / financially responsible person: _____
Insured's social security number: _____
Employer: _____
Family Health Care Provider: _____

BILLING PRACTICES: Billable services provided by a PCC practitioner at school will be billed to the responsible party identified above. Pendleton Community Care will bill insurance companies where applicable. Uninsured students will be billed for services according to their ability to pay. No student will be refused service due to an inability to pay. Unless otherwise indicated, parents will be contacted before billable services are delivered. Please indicate your selection:
□ **Call me before delivering billable service to my child.**
□ **Call me or this other authorized individual before delivering billable service:**
Name and phone of person authorized to consent to service if I cannot be reached:
_____
□ **I do not need to be called before provision of billable routine primary care services to my child.**
***Sign*: _____**

NOTE: By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff encourages every student to involve his/her parent/guardian in health care decisions.

The student named above may receive services in the School-Based Health Center. The Center may release information regarding treatment to my child's regular health care provider, and to third party payors for billing. Information may also be released to comply with statute or regulation on a confidential basis in accordance with acceptable medical practice. I hereby authorize my insurer to mail payment directly to Pendleton Community Care for covered health care services.

_____ _____
Date **Signature of Parent or Legal Guardian**

Provisions of this consent do not preclude School-Based Health Center Staff from providing emergency care requested by the school system for a student under the school system's authority and responsibility for students.