PATIENT REGISTRATION FORM

MRN # ________

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Rogue Community Health to **use and disclose** the health and medical information of ______________________________ for the purposes of Treatment, Payment and Health Care Operations.*

* **Treatment** (includes activities performed by a provider, nurse, lab personnel, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any medical personnel who covers our practice by telephone as the on-call medical personnel.

* **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

* **Health Care Operations** (includes the necessary administrative and business functions of our office). Rogue Community Health is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN). Your health information may be shared by Rogue Community Health with other OCHIN participants when necessary for health care operations.

You may review Rogue Community Health's **"Notice Of Privacy Practices"** for the additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by placing your initials here: _____________.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in our waiting room and web site indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request**. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other medical personnel who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Rogue Community Health has already used or disclosed the information in reliance on this CONSENT.

_______________ ______________________________________ (or)
(Date) (Signature of patient)

_______________ ______________________________________
(Date) (Signature of person authorized by law)

Butte Falls Charter School School-Based Health Center (SBHC)
Parent/Guardian Consent for Student Health Care Services
722 Laurel Avenue, Butte Falls, OR 97522
Butte Falls Charter School SBHC is operated by Rogue Community Health (RCH) in collaboration with Butte Falls School District

Patient/Student Name: ____________________ Grade: ________ Date of Birth: ____________

Address: ____________________ City: ____________ Home Phone: ____________

Who does student live with: ____________________ Preferred Spoken Language: ____________

Your Student may be asked to participate in a satisfaction survey and a health questionnaire every school year

Agreement: Please read carefully and sign at the bottom.

Consent for Treatment:
I consent to treatment necessary for care. I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I allow fax transmittal and/or HIPAA secure electronic submission of medical records, if necessary.

I give permission to the SBHC Registered Nurse, Medical Assistant, or front office staff to provide over-the-counter medication (such as Tylenol, etc.) to my child/student: ☐ No ☐ Yes *Initial:*_______ ***NOTE: If there are changes in allergies, please notify SBHC immediately***

Allergies: *My child has no allergies* ☐, *or* **My child is allergic to:** ____________________

Financial Responsibility:
All patients with self-pay accounts or co-pay requirements are asked to bring in payment at each visit. Patients that have made payment arrangements and/or received a monthly statement are asked to make a payment within thirty days of the statement date. If you have payment concerns, please notify the billing department. We will bill your insurance for you. However, your account remains your responsibility.

Insurance Information: ☐ No Medical Insurance ☐ Private Health Insurance ☐ OHP ☐ Unknown

Name of Insurance Policy holder: ____________________ Date of Birth: ____________

Name of Medical Insurance: ____________________ ID#: ____________ Group #: ____________

Insurance Address: ____________________ Phone #: ____________

If not insured, would you like to be contacted by someone for no-to-low-cost health coverage for children 0 to19 years old? ☐ Yes ☐ No

Insurance Authorization: I understand the financial policy above and accept financial responsibility. By signing below, I assign RCH all payments due from my insurance company for services rendered.

NO ONE IS TURNED AWAY FOR INABILITY TO PAY. Students will receive many services without a fee.

Medical Home
Rogue Community Health (RCH) has a model of care called a Patient Centered Medical Home. This means the clinic is my health care setting where I work in partnership with my care team to address all of my health care needs.

- Does the patient have a regular doctor or Primary Care Physician? ☐ Yes ☐ No
  If yes, please provide the doctor's name: ____________________
- I would like RCH/SBHC to be my child's/student's primary medical provider. ☐ Yes ☐ No

Release of Information: Do we have your permission to:

- Leave message on your home phone regarding the child/student listed above? ☐ Yes ☐ No
- Leave a message on your cell phone? (cell #)____________ ☐ Yes ☐ No
- Leave a message at your place of employment? (work #) ____________ ☐ Yes ☐ No
- Discuss your child's medical condition with any member of your household? ☐ Yes ☐ No
  If yes, ☐ Anyone ☐ Specific: ____________________

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These agreements will remain in effect while the student is enrolled at Butte Falls Charter School or until revoked by me in writing. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

____

Signature of Parent or Guardian Parent or Guardian (Please print)

____

Relationship to Student/Patient Date

Medical Record Number (MRN): *To be filled out by SBHC Staff* ____________________ *Updated 8/2019*

ROGUE COMMUNITY HEALTH- SCHOOL-BASED HEALTH CENTER

Authorization for Release of Information

I, (Client's Name): ________________________________ Date of Birth: ______________,
hereby give permission for ______________________ School-Based Health Center (SBHC) to use and disclose specific health information described below regarding my treatment. I recognize that the information disclosed might contain sensitive information that is protected by federal and state law, and by signing this release I specifically consent to this disclosure:

To release a copy of Behavioral Health information to:

Butte Falls Charter School 720 Laurel Ave. Butte Falls, OR 97522
(Fill in name of individual/facility/agency) *(Address)* *(City, State, Zip Code)*

541-865-3563 541-865-3217
(Phone Number) *(Fax Number)*

I authorize the sharing of the information between: (Must be initialed to be shared).

__________ SBHC and school staff –to be specified:

- _______Principal
- _______Classroom teacher
- _______School counselor
- _______Speech therapist
- _______School psychologist
- _______Family resource worker
- _______Staff contracted through the school district to provide functions related to Protected Health Information
- _______Other______________________
- _______Other______________________
- _______Other______________________

This information will be used on my behalf for the following purposes(s): ______________________

Mental Health related to treatment of CLIENT, including:

- _______ Health Screenings
- _______ Mental Health Assessment
- _______Psychotherapy Notes
- _______ Psychiatric evalution
- _______Verbal communication ______________________
- _______Electronic communication ______________________
- _______Other______________________
- _______Other______________________

School Information related to the CLIENT:

- _______Educational information
- _______Special education record
- _______Psychological evalution
- _______ Other______________________
- _______Other______________________

Special Authorization to Release Information: (Must be initialed to be included)

______ AIDS or HIV _______ Mental Health ______ Drug and Alcohol ______ Genetic Testing

If we are requesting this Authorization from you for our use and disclosure or to allow another health care provider or health plan to disclose information to us:

1. We cannot restrict our services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information from the use of this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature of Client: ______________________ Date: ______________

If the client is unable to sign, is a minor under age 14, or is the ward of a guardian:

Representative's signature: ______________________ Date: ______________

Relationship of representative to client: ______________________