PHSC

Primary Health Services Center

"Champions in Health Care"

School Based Health Center

Parental Consent Packet 2024-2025

www.phsccenter.org

Dear Parent/Guardian

Thank you for choosing to enroll your child in Primary Health Services Center School-Based Health Center (PHSC-SBHC). We are excited about this awesome school year. We want to welcome your family and provide information about our clinics and services. We are excited about partnering with you to offer your child medical, dental and behavioral health services. We now have two clinics located at **Carroll Junior High School, 2945 Renwick St. Monroe, LA 71201 and at Wossman High School, 1600 Arizona Ave. Monroe, LA 71202**.

The PHSC-SBHC must have a parental consent form in order to enroll your child/children. A parent/guardian must sign the consent forms in order for students to receive PHSC-SBHC services. Once consent forms are signed, PHSC-SBHC will provide or refer the student for any services that the child needs. PHSC-SBHC will make **every attempt** to keep parents informed of the services their child receives. However, signing the consent gives the SBHC permission to provide medical, dental and behavioral health services to the child without contacting the parent each time the student visits the PHSC-SBHC.

The PHSC-SBHC has licensed pediatricians, nurse practitioners, physician assistants, nurses, certified medical assistants, behavioral health therapists, dentists and dental assistants who care for students. We will work closely with the school's nurse program and refer out as needed to ensure that your child receives the best care. We are here to help keep your child healthy, in school, and ready to learn. Parents and guardians are welcome to be involved in their children's care, and to contact the center if you have any questions or suggestions.

The services listed below are of the same quality as those performed in a doctor's office. The American Academy of Pediatrics (AAP) encourages these services because they help to prevent disease and keep children healthy.

- Primary and preventative health care – involving a comprehensive history and physical exam.
- Well child check-ups – height/weight/BMI, blood pressure, vision and hearing tests, hemoglobin.
- Immunizations/Vaccinations – Students can get their shots at the health center.
- Nutrition counseling and Health education – Eating healthy foods and learning to make healthy choices.
- Physical exams – Staff will physically examine the child and the different body systems.
- Diagnosis and treatment, including prescriptions for your child sent to your pharmacy of choice.
- Services for sexually transmitted diseases (STDs) – Testing and treatment is provided.
- Chronic Disease Management – such as asthma, diabetes, allergies, etc…
- Acute or Emergency Care – for minor illness and injury and referral for serious illness or injury.
- Behavioral Health Services - Individual time with a counselor to discuss their physical or emotional health.
- Dental Services – Exams and cleanings with a licensed dentist and hygienist. These are available at specific times.

If you already have a medical provider, we will be happy to work with him/her to see that your child gets the best care possible. We are ***not*** trying to replace your regular source of health care. If your child does not have a regular provider, PHSC-SBHC will be happy to have them as a patient. **Medical/Behavioral Health/Dental healthcare services are provided at both school campus locations** during school hours and at **Primary Health Services Center Main Campus at 2913 DeSiard Street Monroe, LA** until 5pm M-F and until 7pm on Thursdays, as well as during school holidays and breaks. Please visit our website at www.phsccenter.org for the most up to date information. 24 hour call coverage provided.

If you have any questions about these services, please contact PHSC's Administrative Offices at (318) 388-1250 **BEFORE** you sign the consent form. If you do **NOT** want your child to receive a service, please put your request in writing and submit it to the PHSC-SBHC staff. The Center is open from 7:30am – 4:00 pm Monday-Friday when school is open. We look forward to working with you and your child!

With Healthy Regards,

Primary Health Services Center Team

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School _____ **Grade** _____ **Chart No.** _____

2024-2025 PATIENT'S CONSENT FORM

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____-_-_____

Sex: ☐ Male ☐Female Grade_____ **Ethnicity**:_____Hispanic___Non-Hispanic

Race:____Black____White____American Indian/Alaskan Native ___ Asian____Pacific Islander___Native Hawaiian____Other _____

Student Address: _____

_____ ___ _____
City State Zip Code

Will the SBHC be the student's regular doctor? ☐ Yes ☐No
If *no*, who is or will be the student's regular doctor?
Name:_____
Telephone:_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name:_____First Name: _____

Father
Last Name:_____First Name: _____

Legal Guardian, If Applicable
Last Name:_____First Name: _____
Relationship of legal guardian to student
☐Grandparent ☐ Aunt or Uncle ☐Other: _____

Contact Information for parent or guardian
Home Tel:_____Work Tel: _____
Cell: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home/Cell #:_____Work #: _____

INSURANCE INFORMATION

Does your child have Insurance coverage? ☐No ☐ Yes:
____ Medicaid ____Medicare
____ Medicare/Medicare ____Private (Please send copy)

(If private): Name of Policy holder: _____
Relationship to Student _____
Health Plan:_____Member ID/Policy Number: _____
Health Insurance Phone: _____

Housing Status:
___ Public Housing____Own a Home____Rent____Other
___ Homeless (If yes, please check mark on current situation.
___ Transitional shelter____Streets____Double-Up (living with

Number in Household_____ Monthly Income _____

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive **medical care** through the School Based Health Centers, PHSC Mobile Health Clinics, and other PHSC locations (examples: physical exams, COVID-19 testing, drawing blood, evaluation of injuries, immunizations/vaccinations/, chronic disease management, and referrals).

I consent for my child to receive **dental care** through the School Based Health Centers, PHSC Mobile Health Clinics, and other PHSC locations (Examples: cleanings, x-rays, sealants, fluoride application.) Some treatments may be delivered by a hygienist or assistant.

I consent for my child to receive **behavioral health/counseling services** through the School Based Health Centers, PHSC Mobile Health Clinics, and other PHSC locations (Examples: one-on-one counseling, insurance assistance, community resource referrals and outreach, and coordination of outside resources and/or services.)

I consent for my child to receive **telehealth** through the School Based Health Centers, PHSC Mobile Health Clinics, and other PHSC locations (Example: services will be delivered through encrypted/HIPAA compliant video and/or audio conferencing that is as equally secure as all electronic medical communication and health records.)

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to PHSC-SBHC staff members, and also for PHSC-SBHC staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization/vaccinations records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, COVID-19 test results, medications, health care plans, or attendance information. The medical and mental health providers from PHSC-SBHC may participate in student success or attendance teams if needed. I authorize/assign payments of authorized benefits directly to PHSC-SBHC. I also authorize other health care providers for the student listed above to release information to PHSC- SBHC members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI, dental and mental health records. I hereby authorize PHSC-SBHC to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize PHSC-SBHC staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, PHSC-SBHC staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I have received a copy of PHSC'S Notice of Privacy Practice, which makes me aware of my privacy's rights and HIPAA.

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PRIMARY HEALTH SERVICES CENTER

Name _____ **Chart No.** _____

Student's Health Status

Child's pediatrician_____Phone_____Last Physical Exam _____

Child's dentist_____Phone_____Last Physical Exam _____

List of allergies to medicines, foods, beestings, etc. _____

List of current medications your child is taking _____

_____Pharmacy_____

Is there any important health information we should know? (Pregnant, history of cancer/ tumor/tuberculosis)

_____

Has your child been hospitalized overnight in the past year? Y / N If yes, why?_ _____

Has your child had any surgeries in the past year? Y/N If yes, describe _____

Would you like to request any other assistance or do you have comments to help us serve you better?

_____

Student and Family History

This information helps us determine proper screening for the student.

	YES	NO	UNSURE	Age of Onset	Student	Mom/Dad	Brother/Sister	Grandparents
Allergies to anesthetics								
Anemia								
Artificial heart valves/ joints								
Asthma								
Bad nerves								
Cancer								
Diabetes								
Heart Disease								
High blood pressure								
Kidney disease								
Mental Illness								
Seizures/epilepsy								
Sickle Cell Disease								
Stroke								
Tobacco use								
Tuberculosis/lung disease								

Sexual Orientation

____ Lesbian/Gay
____ Straight/Heterosexual
____ Bisexual
____ Other
____ Don't Know
____ Choose Not To Disclose

Gender Identity

____ Male
____ Female
____ Transgender Man
____ Transgender Woman
____ Other
____ Choose Not To Disclose

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information.

We may deny your request for an amendment, and if this occurs you will be notified of the reason for denial.

Right to Accounting of Disclosures. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as family member or friends. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we do not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request, or if we believe that it will negatively impact our ability to care for you.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

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If you are concerned about the care that you have received and/or the safety in the organization, please contact the Administrative Office at
2913 Betin Avenue, Monroe LA 71201.
Phone: (318) 388-1250.

Right to a Paper Copy of this Notice:
You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from any of our PHSC locations identified on the front page of this notice.

Changes to this Notice:
We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the bottom right-hand corner. We will also give you a copy of our current notice upon request.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with PHSC or for further information about the complaint process, please contact our Compliance Officer at (318) 388-1250. Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

Desiard Street Primary Care Clinic
2913 Desiard Street
Monroe, LA 71201
(318) 651-9914

Behavioral Health Clinic
2913 Desiard Street
Monroe, LA 71201
(318) 325-7740

Dental Clinic
2914 Betin Avenue
Monroe, LA 71201
(318) 323-4450

Pediatric & Women's Health Clinic (Wellness Center)
2915 Betin Avenue
Monroe, LA 71201
(318) 651-9945

Pharmacy
2913 Desiard Street
Monroe, LA 71201
(318) 654-8756

S. D. Hill Clinic
850 South 2nd Street
Monroe, LA 71202
(318)-651-0041

Mobile Health Clinics
(Serving Ouachita, Lincoln, & Morehouse Parishes)

Grambling Family Health Center
7604 Hwy. 80
Grambling, LA 71245
(318) 596-1700

West Monroe Family Health Center
301 McMillan Road
West Monroe, LA 71291
(318) 737-7616

School Based Health Centers

Carroll Jr. High School
2945 Renwick Street
Monroe, LA 71201
(318) 654-8760

Wossman High School
1600 Arizona Ave.
Monroe, LA 71202

School Based Nurse
Lincoln Preparatory School
407 Central Avenue
Grambling, LA 71245

Family Justice Center
620 Riverside Drive
Monroe, LA 71202

Effective Date: April 13, 2003

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

For Treatment. We may use health care information about you to provide you treatment or service. For example, we may consult with a specialist who lends his/her services to the Health Center about your care or disclose to an emergency room doctor who is treating you for a broken leg, that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payments from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all of your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you may need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for our day-to-day operations, and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations.

These uses and disclosures are necessary to run the Health Center and to make sure that all of our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you.

We may also use and disclose health information:

- To remind you of a Health Center appointment
- To notify you of health related services, benefits and treatments alternatives.
- To individuals involved in your care or payment for your care.
- To organizations that handle organ and tissue donation if you are an organ donor.
- When required by federal, state, and/or local law.
- When there are risks to public health or safety.
- To workers compensation or similar programs providing benefits for work related injuries or illness.
- To military command authorities or the Department of Veteran Affairs
- To health oversight agencies that monitor the health care system, government programs and compliance with civil rights laws.
- In response to a court or administrative order.
- To coroners, health examiners, and funeral directors to the extent needed to carry out their duties.
- To business associates contracted to perform agreed upon services and billing for services.
- To authorized federal officials for intelligence, counterintelligence, protective services for the President/heads of state and other national security activities authorized by law.
- To correctional institution or law enforcement official if you are an inmate or under the custody of a law enforcement official. This release would be for the institution to provide you health care, to protect your safety and safety of others or the safety and security of the correctional institution.

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Research

Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another for the same condition. All research projects however, are subject to a special approval process.

Public Health Activities. We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Your Rights:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them.

Right to Inspect and Copy: You have the right to inspect and obtain a copy of the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. To inspect a copy of your personal health information, you must submit your request in writing to our medical records department. If you request a copy of the information, any applicable costs associated with your request will be compliant with state and/or federal law. We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. We will comply with the outcome of this review.

Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.