PHSC

Primary Health Services Center

"Champions in Health Care"

SCHOOL PHYSICAL PARENTAL CONSENT PACKET

PHSC
PRIMARY HEALTH SERVICES CENTER

PATIENT'S CONSENT FORM

Name:	Date of Birth: (MM/DD/YY)	Age:	Chart Number:
Address:	City:	State:	Zip:
Email Address:	SS#:	Sex: ☐ Male ☐ Female	
Home Phone:	Mobile Phone No.:	Veteran Status: ☐ Veteran ☐ Not a Veteran	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Insurance Type:
- ☐ Medicaid
- ☐ Medicare
- ☐ Medicaid/Medicare
- ☐ Private

Race: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Also check below
☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race
☐ Race Unreported

Number in Household	Monthly Income: $
Emergency Contact Person:	Relationship:	Phone Number:

CONSENT TO TREAT/PROCESS CLAIMS: I do hereby authorize PHSC or any member of their staff, under the direct supervision of appropriate licensed personnel, to provide such medical services to patients as he or she may deem reasonable and necessary to treat me, or my minor child, for any illness, condition, or disease which I am or may be afflicted.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my family physician and/or to my insurance carrier to process any and all claims. And I authorize the release of medical records from other physicians to assist in my treatment.

LABORATORY SERVICES: Please be advised that if Laboratory tests are ordered or collected that our outside laboratory will bill you for all laboratory work. If any charge went towards your insurance, it will be billed to the party (Secondary insurance/patient/patient guarantor).

ADVANCE DIRECTIVES: It is the policy of PHSC as a primary care site NOT to honor any Advance Directives a patient may possess. A minimal of basic life support efforts will be initiated by staff and EMS will be activated. The patient may invoke his/her Advance Directives after being transferred from PHSC to the nearest tertiary care site.

PATIENT RIGHTS: I have received a copy of PHSC's Notice of Privacy Practices, which makes me aware of my privacy rights and HIPAA.

Housing Status:
☐ Public Housing ☐ Own a Home ☐ Family Justice/Well Springs ☐ Rent ☐ Other

☐ Homeless (If yes, please put check mark on current situation:
☐ Transitional shelter ☐ Streets ☐ Doubled-up (Living with someone else)

Signature of Patient/Responsible Person *X*	Date:
PHSC Witness *X*	Date:

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Please Print

Name:_____School:_____Grade:_____Date:_____

Sport(s):_____Sex: M / F Date of Birth:_____Age:_____Cell Phone:_____

Home Address:_____City:_____State:____ Zip Code:_____Home Phone:_____

Parent / Guardian:_____ _Employer:_____ ____Work Phone:_____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease	_____	☐	☐	Sudden Death	_____	☐	☐	Arthritis	_____
☐	☐	Stroke	_____	☐	☐	High Blood Pressure	_____	☐	☐	Kidney Disease	_____
☐	☐	Diabetes	_____	☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Epilepsy	_____

ATHLETE ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion	_____	☐	☐	Neck Injury / Stinger	_____	☐	☐	Shoulder L / R	_____
☐	☐	Elbow L / R	_____	☐	☐	Arm / Wrist / Hand L / R	_____	☐	☐	Back	_____
☐	☐	Hip L / R	_____	☐	☐	Thigh L / R	_____	☐	☐	Knee L / R	_____
☐	☐	Lower Leg L / R	_____	☐	☐	Chronic Shin Splints	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____	☐	☐	Pinched Nerve	_____
☐	☐	Chest	_____	Previous Surgeries: _____							

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Murmur / Chest Pain / Tightness	☐	☐	Asthma / Prescribed Inhaler	☐	☐	Menstrual irregularities: Last Cycle:_____
☐	☐	Seizures	☐	☐	Shortness of breath / Coughing	☐	☐	Rapid weight loss / gain
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Take supplements/vitamins
☐	☐	Irregular Heartbeat	☐	☐	Knocked out / Concussion	☐	☐	Heat related problems
☐	☐	Single Testicle	☐	☐	Heart Disease	☐	☐	Recent Mononucleosi
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Liver Disease	☐	☐	Sickle Cell Trait/Anemia
☐	☐	Organ Loss (kidney, spleen, etc)	☐	☐	Tuberculosis	☐	☐	Overnight in hospital
☐	☐	Surgery	☐	☐	Prescribed EPI PEN	☐	☐	Allergies (Food, Drugs)_____
☐	☐	Medications _____						

List Dates for: Last Tetanus Shot:_____ Measles Immunization:_____Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary……....**Yes** **No**
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately……..**Yes** **No**
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school……..**Yes** **No**
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its representative(s) or the associated medical personnel. ……**Yes** **No**

_____ _____ _____

Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

Health Care Provider section on page 2

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Name:_____ Date of Birth:_____ Age:_____ Date:_____
School:_____ Grade:_____Sport(s):_____

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____	Weight _____	Blood Pressure_____	Pulse_____

GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

Health Care Provider notes (if needed):_____

[ ] Medically eligible for all sports without restriction

[ ] Medically eligible for certain sports_____

[ ] Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of _____

[ ] Not medically eligible pending further evaluation

[ ] Not medically eligible for any sports

This recommendation is from a limited screening.

_____	_____	_____
Printed Name of MD, DO, APRN or PA	**Signature of MD, DO, APRN or PA**	**Date of Medical Examination**

Revised 5/23 **This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.**

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PRIMARY HEALTH SERVICES CENTER

Authorization to Release or Obtain Health Information

Name of Patient:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security No.:
I Authorize: (indicate name of Person/Party being authorized): **Primary Health Services Center**	Relationship to Patient:
Mailing Address: **2913 Betin Avenue**	City/State/Zip: **Monroe, LA 71201**

☒ **RELEASE** Information **TO** or ☒ **OBTAIN** Information **FROM**
(Place an "X" on the box if the information is being released OR requested.)

Name:	Mailing Address:
Telephone Number:	City/State/Zip:

Purpose of Authorization is indicated in the box(es) below. Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for disclosure to a third party. ☐ Others (Specify)_____

I authorize the release of the following protected health information. *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records ☐ Laboratory Reports
☐ X-ray Reports ☒ Other: LHSAA MEDICAL HISTORY EVALUATION

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

	☐ Alcoholism	☐ Drug Abuse	☐ Mental Health	☐ Vocational Rehabilitation	☐ HIV (AIDS)
	☐ Sexually Transmitted Diseases		☐ Genetics	☐ Psychotherapy Notes	
	☐ Other				

This authorization shall expire on: (Date or Event)	Signature of Individual or Personal Representative authorized by law:	Date:

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION:

We may need your authorization to use, disclose or obtain your health information for some of our services. You do not have to sign this form. If an expiration date is not entered, the authorization will expire one (1) year from the date signed.

A separate signed authorization form is required for the use and disclosure of health information for:
☒ Psychotherapy notes ☒ Employment-related determinations by an employer ☒ Research purposes unrelated to your treatment

When required by law or policy, PHSC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.
☒ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by l aw or policy, PHSC will use and disclose your health information as you have authorized on the signed authorization form.
☒ You may be required to sign an authorization before receiving research-related treatment.
☒ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. Example: In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by PHSC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to PHSC.

☒ You may cancel an authorization in writing at any time. PHSC cannot take back any uses or disclosures already made before an authorization was cancelled.
☒ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by PHSC privacy policies.

Revised 2/6/2018

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

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.