PrimaryOne Health
School-Based Health Program
www.primaryonehealth.org

It's fast and easy for your child to receive health care services through the PrimaryOne Health Groveport Madison School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that the Groveport Madison School District will soon have a School Based Health Center (SBHC)! The SBHC is run by PrimaryOne Health. The SBHC is staffed by licensed professionals consisting of medical, dental, vision and mental health.

Please know that your child can use the School-Based Health Center and see your other doctors as well. Signing this consent does not change your insurance, does not change your primary care doctor.

At the School Based Health Center, your child can receive the services listed below, regardless of insurance status. The SBHC is allowed to bill insurance, and you may receive a bill for services. If you do not have insurance, PrimaryOne Health offers a sliding fee scale.

Based on 2023 Federal Poverty Guidelines which are in effect as of January 16, 2023

	2023 Sliding Fee Schedule -Based on Annual Income Federal Poverty Level				
Household Size	100%	125%	150%	175%	200%
1	$ 14,580	$ 18,225	$ 21,870	$ 25,515	$ 29,160
2	$ 19,720	$ 24,650	$ 29,580	$ 34,510	$ 39,440
3	$ 24,860	$ 31,075	$ 37,290	$ 43,505	$ 49,720
4	$ 30,000	$ 37,500	$ 45,000	$ 52,500	$ 60,000
5	$ 35,140	$ 43,925	$ 52,710	$ 61,495	$ 70,280
6	$ 40,280	$ 50,350	$ 60,420	$ 70,490	$ 80,560
7	$ 45,420	$ 56,775	$ 68,130	$ 79,485	$ 90,840
8	$ 50,560	$ 63,200	$ 75,840	$ 88,480	$ 101,120
Each additional person, add	$ 5,140	$ 6,425	$ 7,710	$ 8,995	$ 10,280

School Based Health Center Services include:

- Physical examinations
- Prescriptions
- Well Child Visits
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions
- Age appropriate reproductive health care
- Health Education and Counseling
- Mental Health Counseling and services
- Screening including; hearing, asthma, obesity, and other medical conditions;
- Dental Services
- Complete Vision Services including glasses

To register your child for the services of our School Based Health Center, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

The School Based Health Center is located at 4400 Marketing Place, Suite D, Groveport OH 43125. The Health Center is open Monday - Friday from 8:00 am – 5:00 pm. You can call us at (614)586-4310 for more information.

We look forward to meeting you and we look forward to providing health services to your child.

Sincerely,

Molly Bean,
SBHC Liasion
School Based Health Centers
PrimaryOne Health

PrimaryOne Health School Based Health Center
Parental Consent Form

Health Care Service Provider Address: *4400 Marketing Place, Suite D, Groveport, OH 43215*
Telephone: *(614)586-4310* ***Fax:*** *(614)586-4321*
*Name of School****: Groveport Madison Welcome Center***

Please know that your child can use the School-Based Health Center and see your other doctors.
Signing this consent <u>does not</u> change your insurance, <u>does not</u> change your private doctor, and <u>does not</u> affect the number of times your child can see their private doctor.

STUDENT INFORMATION

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year

Student Address:_____
_____
City State Zip Code

Student email:_____
PreferredLanguage:_____
***Student Social Security Number:** _____
Sex: ☐Male ☐Female Grade _____
Race: __Hispanic __Black __White __Asian/ Pacific __ Other__
Ethnicity: ☐Hispanic ☐Black ☐White ☐American Indian ☐Asian/Pacific Islander ☐Other _____
List the student's primary care doctor, if they have one?
Name: _____
Telephone: _____
Address: _____

Indicate the Pharmacy where we can send prescriptions.
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____
***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

<u>Parent/ Legal Guardian:</u>
Last Name: _____ First Name: _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

<u>Parent/Legal Guardian:</u>
Last Name: _____ First Name: _____
Home/Work Tel:_____
Cell Phone:_____
Email :_____

If legal guardian , relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: _____
Home/Work Tel: _____
Cell: _____
Email: _____
Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?
☐No ☐Yes: Medicaid ID # _____

Does your child have Healthy Start?
☐No ☐Yes: # _____

Which Plan?
❑ Buckeye Health Plan ❑ Paramount Advantage
❑ CareSource ❑ United HealthCare
❑ Molina ❑ Other _____

Does your child have other health insurance
☐No ☐Yes, Health Plan: _____
Member ID/Policy Number: _____
Subscriber Name:_____
Subscriber DOB: _____
Relationship to Patient_____
Insurance Billing Address_____
Insurance Phone :_____

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the <u>PrimaryOne Health</u> School-Based Health Center. By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents, married or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

X _____ _____
Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in Box 2 on reverse side of this form. My signature indicates my consent to release medical information as specified in the box 2 section only.

X _____ _____
Date

SCHOOL BASED HEALTH CENTER SERVICES — BOX 1

I consent for my child to receive health care services provided by the State-licensed health professionals of PrimaryOne Health School-Based Health Center as part of the school health program. I understand that I have the right to make informed decisions about my health care treatment. I give permission for PrimaryOne Health staff, medical consultants, behavioral health, and other health consultants to provide all services necessary to diagnose, treat, and care for my needs. I know that I can ask any person providing care to me questions I have about my treatment I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuber-culosis and other medical conditions, first aid, and required and recommended immunizations.
2. Physical examination (Medical examination) including those for school, sports, and working papers.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medica-tions.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. For Adolescent Students: Reproductive health care services, including STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Dental examinations including: diagnosis, x-rays, treatment, and sealants where available.
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.

FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION — BOX 2

By signing this Consent for Health Services/Treatment, I agree to the terms and conditions regarding the Authorization to Release Information and Assignment of Insurance Benefits as explained in this consent form on page 2. I also acknowledge that I have received information about how to receive Notice of Privacy Practices as explained in this consent.

I understand that I will be notified of any services my child receives, as well as any abnormal findings and/or further treatment recommendations. For services provided by PrimaryOne Health, I understand I should call the phone number listed on the After Visit Summary which will be sent home with my child. I understand this consent will remain valid throughout the 2023-2024, 12 month academic year unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that School-Based Supplemental Health Services remove my child from services. It is my responsibility to notify PrimaryOne Health of all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage.

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms PrimaryOne Health at the Health Center . I know I also can view them online at http://columbus.gov/schoolbasedhealthservices/. Copies of the consent form are available at my child's school and blank forms are also available at http://primaryonehealth.org

Authorization to Release Information: I hereby authorize PrimaryOne Health to exchange information with the Groveport Madison school nurse(s), school counselor and/or school social worker for the exclusive purpose of treatment or care coordination. Administered immunizations will be entered into the statewide immunization information system (Ohio ImpactSIIS). Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987). School-Based Supplemental Health Services may use student health records to evaluate the quality of care provided and the effectiveness of offering these services. My child's records are protected and can only be accessed by authorized users with restricted access. I understand this authorization will remain valid throughout the 2023-2024, 12 month academic year unless revoked by me. I may revoke this authorization at any time by providing written notice of my intent to revoke to School-Based Supplemental Health Services.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. With this Authorization, you agree that we, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Health Center Administrator.

Insurance Information: Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. Some School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. I give PrimaryOne Health the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which a benefit may be available to pay for services provided to my child through School-Based Supplemental Health Services.

_____I agree to allow PrimaryOne Health access to my child's individual academic, attendance and behavior records for the current and prior school years so they can provide better services to my child.

_____I DO NOT agree to allow PrimaryOne Health access to my child's individual academic, attendance and behavior records for the current and prior school years so they can provide better services to my child.

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page **To**: Date that student is no longer enrolled in the SBHC

PrimaryOne Health

BASIC HEALTH HISTORY

School-Based Health Program

Dear Parent/Guardian: Your child's health is important to us. To help the Health Center better understand their healthcare needs, and/or to care for them in case of an emergency, please fill out this brief and confidential health history form.

Child's Name	Date of Birth (mm/dd/yyyy)	School	Grade

Your child's health history	Yes	No	Not Sure
Does your child have any allergies to medications? If yes, what are they:			
Does your child have any food allergies? If yes, what are they:			
Have there been any changes in your child's health in the past year? If yes, what are they:			
Does your child take any medications regularly? If yes, what are they:			
Has your child ever had chicken pox before? If yes, at age:			
Has your child ever been hospitalized or had surgery? If yes, for what?			
Does your child have a doctor you go to and like outside of school? When was their last complete health exam/physical? Date:			
Does your child have a dentist you go to and like outside of school? When was their last dental visit? Date:			

Does your child have any health conditions or issues:	Yes	No	Not Sure
Allergies (seasonal/environmental)			
Anxiety/depression (circle one or both if yes)			
Asthma			
Attention Deficit Disorder			
Diabetes			
Obesity			
Other:			

If your child comes to the Health Center would you like to be called BEFORE your child is seen by the practitioner?

Circle one: Yes No

Name	Date (mm/dd/yyyy)
Signature	
Relationship to child	

The OH Dept of Health requires these questions about risk for tuberculosis and lead intoxication:	Yes	No	Not Sure
Has your child ever had tuberculosis or a positive skin test for tuberculosis? If yes, at age:			
Has your child been around anyone with tuberculosis (TB) disease? If yes, when? Who?			
Does your child have a close contact or live with a person who has a positive TB skin test? If yes, when? Who?			
Has your child lived in the US for less than 5 years? If yes, where else have they lived:			
Has your child travel outside the US for more than one month at a time? If yes, where?			
Has your child traveled to, or used products (like glazed pottery, folk remedies, cosmetics, food, spices) imported from Haiti, Mexico, Pakistan, the Dominican Republic, or Bangladesh?			

Who does the child live with most of the time?

In the past year, have there been any major changes in your family?
Eg: Marriage, Divorce, Deaths, New School, Serious Illness, Births, etc.

Have any other family members, living or deceased had any of the following problems? Check all that apply.	NA	Mother	Father	Sibling	Grand-parent
Asthma					
Blood disorders/sickle cell anemia					
Mental health issue (depression/anxiety)					
Diabetes					
Heart attack or stroke before age 50					
High blood pressure					
High cholesterol					
Obesity					
Smoking tobacco cigarettes/cigars					
Other:					

Please call the health center with any questions. *Thank you!*

PrimaryOne Health

SBHC School-Based Health Center