Spartanburg Regional Healthcare System

SPATANBURG MEDICAL CENTER

CENTER FOR PEDIATRICS

SCHOOL-BASED CLINIC
CONSENT FOR TREATMENT

Student Name: _____

I hereby consent for my child, named above, to receive medical care from the School-Based Health Program, which is operated by my child's school district and Spartanburg Medical Center – Center for Pediatrics. I understand that care will be provided in a private manner and information will not be released without my consent. I expressly permit physicians or designated health professionals to provide necessary and/or advisable treatment for my child and to bill for services rendered. I understand that supervised residents and students may assist in my child's care, and I understand that my child may receive medical care from providers, who are authorized by my child's school district but who are otherwise not affiliated with Spartanburg Medical Center – Center for Pediatrics.

I authorize Spartanburg Medical Center to release information necessary to any third party responsible for payment of medical services (including Medicare, Medicaid, and commercial third-party payors).

I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles. I understand this consent form is valid, until I revoke it.

I received a copy of the Spartanburg Medical Center "Notice of Privacy Practices," and do not have any questions.

_____ _____
Signature of Legal Guardian/Representative Date
(of Student if 18 years or older or otherwise permitted by law)

_____
Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

Patient Identification Label

Patient Name _____

MRN_____

Form Origination Date: 3/2018

Version 1 Version Date: 3/2018

Spartanburg Regional Healthcare System

SPARTANBURG MEDICAL CENTER
CENTER FOR PEDIATRICS
SCHOOL-BASED AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name:_____

By signing this authorization, I hereby give my child's school-based clinic, the school nurse and my child's healthcare provider(s) consent to share medical information about my child with Spartanburg Medical Center – Center for Pediatrics as needed, which information will be protected as confidential information.
The purpose of the disclosure is: participation in school-based health services.
The protected health information to be shared includes any and all records. Examples of protected health information that may be shared include, but are not limited to, the following:

- Medical history (including any medical diagnosis and treatment)
- Physical examinations
- Consults
- Lab Reports
- Listing of current medications

I understand this information may include references to psychiatric/psychological care, sexual assault, drug abuse, results of tests for all infectious diseases (including HIV/AIDS), and/or alcohol abuse.

I understand that this information may be exchanged by mail, fax, email, phone or a secure web-based software.

I understand that I have a right to cancel this authorization at any time, which must be in writing and presented to the School-Based Health Program office. I understand that such cancellation will not apply to information that has already been released in connection with this authorization, and that this authorization form is valid for one year after the date signed until I revoke it unless I enter a different date here: _____.

I understand that permitting the release of protected health information is voluntary, and that I can refuse to sign this form. I do not need to sign this form to receive treatment. I may review and/or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of re-disclosure by the person/organization receiving the information. I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years of age or older.

_____ _____
Signature of Legal Guardian/Representative (of Student if 18 years or older or otherwise permitted by law) | Date

_____ _____
Printed Name of Legal Guardian/Representative (or Student if 18 years or older or otherwise permitted by law) | Relationship to Patient

To contact the School-Based Health Program office at Spartanburg Medical Center – Center for Pediatrics, in writing the address is 853 North Church Street – Suite 401, Spartanburg SC 29303; the phone number is (864) 560.6287.

Version 1 Version Date: 3/2018

Patient Identification Label

Patient Name _____

MRN_____

Spartanburg Regional Healthcare System

SPARTANBURG MEDICAL CENTER
CENTER FOR PEDIATRICS
SCHOOL-BASED CLINIC
PATIENT DEMOGRAPHIC FORM

Grade: _____ Teacher Name: _____

Patient Name: _____
Last First Middle

Patient Birthdate: _____ Age: _____ Primary Language: ❑ English ❑ Spanish ❑ Other

Sex: ❑ Male ❑ Female Social Security #: _____

Race: ❑ Black ❑ White ❑ Hispanic ❑ Asian ❑ Multiracial ❑ Other_____

Primary Care Provider: _____

Parent or Guardian Name: _____

Relationship to Patient: _____ Parent or Guardian Birthdate: _____

Parent or Guardian Social Security #: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone:_____ Cell Phone:_____

List the name and contact information of a person (or persons) we can contact if parents/guardian cannot be reached.

Emergency Name:_____ Phone:_____

Relationship to Patient _____

PROVIDE PATIENT INSURANCE INFORMATION – Include a copy of the front and back of your Medicaid/Insurance Card.

❑ 1. Medicaid #:_____ Medicaid Plan_____

❑ 2. Private medical health insurance:
Name:_____ Policy #_____
Who (name) insures child? Relationship to insured child: _____
Employers Name: _____

❑ 3. No insurance

Version 1 Version Date: 3/2018

Patient Identification Label

Patient Name _____

MRN_____

Spartanburg School District 7 Consent to Bill Private Insurance and Medicaid

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Spartanburg School District 7 Consent to Bill Private Insurance and Medicaid Spartanburg School District 7 (District) and the South Carolina Department of Education (SCDE) have my permission to provide services to my child and release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services (SCDHHS) and any applicable third-party insurer regarding billable services provided to my child. I understand the purpose of this consent is to bill Medicaid and/or private third-party insurer for services under the Individuals with Disabilities Education Act (IDEA). By signing this form, I give the District and the SCDE my permission to bill and receive payment from Medicaid and any third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an individualized education program (IEP). The District provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to my signing this consent to release information to bill Medicaid or any third-party insurer and prior to accessing Medicaid or my child's third-party insurance benefits. I further understand that the District must provide me annual written notification of my rights relative to Medicaid or any third-party insurer accessing my child's information and before the District and the SCDE access my benefits to pay for services under the IDEA. This consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually thereafter, unless there is a change in the type or amount of services to be provided to my child or a change in the cost of the services to be charged to Medicaid or a third-party insurer. I understand that Medicaid and third-party insurance reimbursement for billable services provided by the District and the SCDE will not affect any other Medicaid services or insurance benefits for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether my child is covered by public or private insurance programs and regardless of whether I provide consent to access those benefits. I understand that my refusal to consent to the SCDHHS or any third-party insurer accessing my child's personally-identifiable information does not relieve the District of its responsibility to ensure that all required services in my child's IEP are provided at no cost to me. I understand that this consent is voluntary on my part and may be revoked at anytime. If I later revoke consent, the revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked). I also understand that the District and the SCDE will operate under the guidelines of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of services.

Student's Name: _____ DOB: _____ Medicaid #: _____ Signature of

Parent/Guardian: _____ Date: _____

CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

I understand that Spartanburg School District 7 (the "District") is subject to the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and State and District policies and procedures to ensure confidentiality of student information.

My signature below documents my permission for the District to release medical, psychological and other personally-identifiable confidential information about my child, as necessary, to representatives of the School-Based Health program operated in partnership with Spartanburg Medical Center – Center for Pediatrics. I understand that the purpose of this release is to equip my child's provider with the information he/she needs to provide health-related services and treatment to my child.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, such revocation is not retroactive (i.e. it does not negate an action that has occurred after the consent was given and before the consent was revoked and I understand this consent form is valid until I revoke it.

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected by FERPA.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Signature of Parent/Guardian/Surrogate Parent Date

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