



**PRIMARY HEALTH SOLUTIONS
SCHOOL BASED HEALTH CENTER
ENROLLMENT PACKET**



Welcome to Primary Health Solutions School Based Health Center.

This center is very unique being school based. It offers the students and community members access to medical care when it might otherwise not be available. We operate year round and during the school year offer **NO COST** transportation from the schools in the district to the health centers and back. The parents/ guardians are always welcome at the appointments, but are not required to be there. After the first year, only items that change need to be completed. Examples - grade in school, school building, addresses, phone numbers, medical history, insurance information, etc.

Once the students completed consent and history are received, we will begin scheduling appointments for approved services. You will receive a notice of the student's appointment time by phone or note from school. If we do not receive a request to change the appointment, we will proceed as scheduled.

- Complete the required documents and return to school with the student or drop off at the health center.
- Scheduling may be delayed if there are missing documents or information is illegible.

Please feel free to contact us during regular business hours at **(513) 454-1111**, if you have any questions.

STUDENT INFORMATION & CONSENT FOR SERVICES				
Today's Date: Month / Day / Year	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth: Month / Day / Year
Student's School:	Student's Building:	Student's Grade:	Student's School ID #:	

PRIMARY CARE SERVICES

- YES**, I consent for my child to receive **MEDICAL CARE** including well child exams (includes work, daycare, and sports physicals), appropriate immunizations, appropriate behavioral evaluations and treatment for illness or injury including over the counter medications unless emergency services are needed.
- NO**, I do not wish for my child to receive **MEDICAL CARE** at the School Based Health Center (SBHC)

DENTAL SERVICES

- YES**, I consent for my child to receive **DENTAL SERVICES** at the school based / mobile dental office including preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants and other preventative procedures will also be provided. The treatment plan will be provided and approved by the parents/ guardian **PRIOR** to starting treatment.
- NO**, I do not wish for my child to receive **DENTAL SERVICES** at the SBHC.

VISION SERVICES

- YES**, I consent for my child to receive **VISION SERVICES**, which may include comprehensive eye examinations (including dilation), vision therapy, and fitting/ dispensing of vision correction.
- NO**, I do not wish for my child to receive **VISION SERVICES** at the SBHC.

TRANSPORTATION SERVICES

- YES**, I consent for my child to be **TRANSPORTED/ACCOMPANIED** to and from the SBHC by a school designee. I, the parent or guardian of above named student, release Primary Health Solutions, its Board members, its employees and authorized agents/representatives from any and all liability to personal injury or damage resulting from the transportation to or from the school for these purposes.
- NO**, I do not wish for my child to be **TRANSPORTED/ACCOMPANIED** to or from school for these purposes

By signing this consent, I agree to the terms and conditions regarding Payment for Services & Sharing of Health Information as explained in the accompanying Program Description form. I have also received and agree with the Patient Consent for use and Disclosure of Protected Health Information as explained in the Program Description form. I have received the Notice of Privacy Practices.

Parent or Guardian Signature or Patient/Student Signature (Only if 18 or older)	Parent/Guardian Printed Name or Patient/Student Printed Name (Only if 18 or older)	Date
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**PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM**



Today's Date: / /

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year
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<input checked="" type="checkbox"/> Birth Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	<input checked="" type="checkbox"/> Gender Identity: <input type="checkbox"/> Choose not to Disclose <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM) Transgender Male <input type="checkbox"/> Genderqueer, neither exclusively Male or Female <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female, (MTF) Transgender Female <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Sexual Orientation: <input type="checkbox"/> Choose not to Disclose <input type="checkbox"/> Straight, Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, Gay, Homosexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Other
<input checked="" type="checkbox"/> Current Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (if different)	City	State	Zip

<input checked="" type="checkbox"/> Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Nepali <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____	<input checked="" type="checkbox"/> Religion: <input type="checkbox"/> Christian <input type="checkbox"/> Agnostic <input type="checkbox"/> Atheist <input type="checkbox"/> Buddhist <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> Islamic <input type="checkbox"/> Scientology <input type="checkbox"/> Other: _____	<input checked="" type="checkbox"/> Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Other: _____	<input checked="" type="checkbox"/> Student Status: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student
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<input checked="" type="checkbox"/> All that apply: <input type="checkbox"/> Veteran <input type="checkbox"/> Smoker <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Visually Impaired	<input checked="" type="checkbox"/> Can we send notifications? <input checked="" type="checkbox"/> All that Apply: <input type="checkbox"/> Opt Out <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Voicemail	<input checked="" type="checkbox"/> Which Contact # You Prefer: <input type="checkbox"/> Home Phone # () <input type="checkbox"/> Day/Work Phone # () <input type="checkbox"/> Cell/Alternate # ()
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Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone # ()
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Patient/Guardian Email Address

EMPLOYMENT INFORMATION:

Employer Name	Occupation	Employer Phone #
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STATISTICS REQUIRED FOR GOVERNMENTAL REPORTING:

<input checked="" type="checkbox"/> Tax Filing Status: <input type="checkbox"/> Return Not Filed <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Head of Household Is Head of Household: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> All that Apply: <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant Farm Worker <input type="checkbox"/> Language Barrier	<input checked="" type="checkbox"/> Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> More than One Race	<input checked="" type="checkbox"/> Ethnicity: <input type="checkbox"/> Decline <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown
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ADVANCED DIRECTIVE:

Do you have a living will? Yes No Is it on file with your Primary Care Provider? Yes No

FOR STAFF USE ONLY

Portal Enrollment Reviewed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, Reason:</i> <input type="checkbox"/> Patient Already Enrolled <input type="checkbox"/> Other: _____
Token Generated:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, Reason:</i> <input type="checkbox"/> Patient Already Enrolled <input type="checkbox"/> Other: _____
Reason for No Email:	<input type="checkbox"/> Declined (Refuse) <input type="checkbox"/> Deferred (Self-Enroll) <input type="checkbox"/> No Email

PHS Staff Name (Print)	PHS Staff Signature	Date of Signature
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**PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM**



Today's Date: / /

FINANCIAL INFORMATION REVIEWED - NO CHANGES

RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient):

Last Name	First Name	MI	Social Security #	Birth Date Month / Day / Year	Relationship
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INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship
Tertiary Insurance	Policy #	Group #	Effective	Co-Pay \$	Policy Holder	Relationship

HOUSEHOLD INCOME:

It is the policy of Primary Health Solutions to provide essential services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Discounts will be based on income and family size, only. Please complete the following information to determine if you or members of your family are eligible for a discount.

**For the purpose of assistance, family is defined as: a group of two people or more related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.*

Section (a): Total combined Income for all persons working in the household. **Section (b):** How often you get paid. **Section (c):** Any additional income received in the household. **Section (d):** Total number of people the household income supports.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

(a) Total Household Income before Taxes: \$	(b) <input checked="" type="checkbox"/> Frequency: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	(c) Other Income: \$	(d) Total Number of People Supported by Income:
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DOCUMENTATION OF NO INCOME:

If you have reported \$0 household income in the section above, please explain how you are meeting your daily needs.

ACKNOWLEDGEMENT & CONSENT:

I understand that to determine eligibility for the sliding fee program, I must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). If Self-employed, I must submit detail of the most recent three months of income and expenses for the business. Primary Health Solutions may request additional information before the patient named above is approved for a discount.

I agree to inform Primary Health Solutions of any changes in circumstance that may affect the patient's eligibility. Any intentional false or fraudulent information provided will be grounds for denial of services for the patient. I understand the information above must be updated every twelve (12) months, or if there are any changes in family size or household income.

I have received information explaining the Sliding Fee Scale Program and I agree to follow its terms. I understand that any discount I am eligible for, will apply to all services received at any of the Primary Health Solutions practices, but not those services or equipment that are purchased from outside, including reference laboratory testing, medications, and x-ray interpretation by a consulting radiologist, and other such services.

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the attending provider/ physician. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Primary Health Solutions. I authorize the release of information to my insurance carrier and authorize payment directly to Primary Health Solutions. I have read and fully understand the above.

_____ Parent/ Guardian Signature or Patient/Student Signature (Only if 18 or older) <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	_____ Print Name of Parent Guardian or Patient/Student (Only if 18 or older)	_____ Date of Signature
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****FOR STAFF USE ONLY****

Income Documents Received: Yes No *If No, Reason:* One Day Slide Refused Other: _____
 Documents Scanned: Yes No *If No, Reason:* _____
 Insurance Card Scanned: Yes No *If No, Reason:* _____

_____ PHS Staff Name (Print)	_____ PHS Staff Signature	_____ Date of Signature
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PRIMARY HEALTH SOLUTIONS (PHS)



Today's date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year
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Acknowledgement Of Receipt Of Privacy Practices

We are required to give each patient a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most efficient way possible.

- May we send/receive clinical information from health care providers participating in your care? Yes No
- If you have an answering machine at home, may we leave a message? Yes No
- May we leave a message at your work for you to call our office? Yes No
- Is there a person at your house that we may leave a message with? Yes No

If yes, please provide household members name: _____

List below any person/persons authorized by you to discuss/receive/access your medical information:

Last Name:	First Name:	Relationship to Patient:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

By signing below, I authorize PHS to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practices that I have received.

Patient Name (Print)

Guardian's Name (Print)

Relationship to Patient

Parent or Guardian Signature or Patient/Student Signature (Only if 18 or older)

Date

Check here if you refuse to sign the acknowledgement of Receipt of Privacy Practices.

Our Privacy Officer can be reached as follows:

Name of Privacy Officer: Peggy Vazquez
Practice Address: 300 N. High Street, 4th Floor
 Hamilton, OH 45011
 Phone: (513) 454-1111

PHS Staff Signature

Date



PRIMARY HEALTH SOLUTIONS STUDENT HOME, SCHOOL, & HEALTH HISTORY FORM



Today's date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year
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HOME HISTORY	YES	NO	COMMENTS
Does anyone in the home smoke?			
Has your child been a victim of abuse/ bullied?			
Has your child seen someone abused?			
Do they get enough to eat?			
Is there a gun in the home?			
What activities / hobbies do they enjoy?			

SCHOOL HISTORY	YES	NO	COMMENTS
Are there any learning problems/ disabilities?			
Are they in special classes or have an IEP?			
Have they repeated any grade?			
Do they get into trouble often at school?			
Are any of the responses above different from the past?			
What are their grades?			

MEDICAL/DENTAL/EYE HISTORY	YES	NO	COMMENTS
Date of last physical exam (Head-to-Toe)	Date of Exam:		Providers Name:
Do they take any medications currently?			
Have they previously taken medications?			
Are they allergic to any medications?	Pharmacy Name:		Pharmacy Phone#:
Preferred Pharmacy			
Have they ever been pregnant?	# of Pregnancies:		# of Living Children:
Ever in hospital overnight?			
Any previous surgeries?			
Any previous head injuries?			
Any developmental delays?			
Immunizations up to date?			
Other Medical Concerns?			
Date of last complete dental exam:	Date of Exam:		Providers Name:
Any dental pain?			
Do they brush their teeth?	<input type="checkbox"/> Only morning	<input type="checkbox"/> Only night	<input type="checkbox"/> Both morning and night <input type="checkbox"/> Rarely <input type="checkbox"/> Never
Do they floss?	<input type="checkbox"/> Only morning	<input type="checkbox"/> Only night	<input type="checkbox"/> Both morning and night <input type="checkbox"/> Rarely <input type="checkbox"/> Never
Have they ever had fluoride treatments?			
Have they learned the importance of primary teeth?			
Other Dental Concerns?			
Date of last complete eye exam.	Date of Exam:		Providers Name:
Have they had glasses in the past?			
If yes, do they still have them, wear them?			
Trouble seeing things close?			
Trouble with changing distance?			
Headaches with vision related tasks?			
Other Eye Concerns?			
Any other information we should be aware of?			



PRIMARY HEALTH SOLUTIONS STUDENT HOME, SCHOOL, & HEALTH HISTORY FORM



Today's date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year
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Does student or any family member have or had any of following problems?

PROBLEM	STUDENT <input type="checkbox"/> YES	FAMILY <input type="checkbox"/> YES	PROBLEM	STUDENT <input type="checkbox"/> YES	FAMILY <input type="checkbox"/> YES	PROBLEM	STUDENT <input type="checkbox"/> YES	FAMILY <input type="checkbox"/> YES
Asthma/ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fainting w/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Food	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus issues	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Pets	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/ Frequent	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Concern	<input type="checkbox"/>	<input type="checkbox"/>	Sleep issues	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylactic Rxn	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat/ Frequent	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Issues	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ache/Frequent	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt(s)	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Testicle not in Sac	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Toothache/Dental	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Lead Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	Twitching Eyelid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Underweight	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol High	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections/Frequent	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Lumps Groin/Breast	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Twitch/Tics	<input type="checkbox"/>	<input type="checkbox"/>			
Dizzy/Light Headed	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/Frequent	<input type="checkbox"/>	<input type="checkbox"/>			
Dry/Burning Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>			
Eczema/Skin Infection	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>			
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			

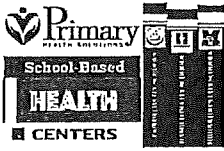
By checking this box I am acknowledging that I have reviewed the document and there is no student or family history of the problems listed above.

Parent or Guardian Signature or Patient/Student
Signature (Only if 18 or older)

Parent/Guardian Printed Name or Patient/Student
Printed Name (Only if 18 or older)

Date

**THE FOLLOWING PAGES
ARE FOR YOU
TO REVIEW
AND
KEEP FOR YOUR
RECORDS**



PRIMARY HEALTH SOLUTIONS SCHOOL BASED HEALTH CENTER PROGRAM DESCRIPTION



Welcome to Primary Health Solutions' School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child without having to take time away from work and minimize the time that your child is out of the learning environment.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, dental care, eye exams, and all associated health care concerns. Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, attempts will be made to contact you as necessary.
- **The School-Based Health Center does not take the place of your primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with that PCP and a summary of your child's visit at the SBHC will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and can become your child's PCP. If your child is already a patient of any Primary Health Solutions locations, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call **(513) 454-1111**.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Primary Health Solutions sliding fee scale. This information will be kept strictly confidential.

If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at Primary Health Solutions. If your insurance does not cover Primary Health Solutions, you will be responsible for the bill at the appropriate discounted fee based on your household income.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid. You may stop by our center or call **(513) 454-1111**.
- You may also contact the Butler County Job and Family Services Department at (513) 887-5600.

Regarding the SHARING OF HEALTH INFORMATION

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's PCP.
- Primary Health Solutions, the School-Based Health Center and/or the school nurses will share medical information, including immunization records, with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

- With my consent, School-Based Health Center or Primary Health Solutions may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Primary Health Solutions' Notice of Privacy Practice for a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practice prior to signing this consent. Primary Health Solutions reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Primary Health Solutions at, 300 High Street, 4th Floor, Hamilton, OH, 45011.
- With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.
- With my consent, School-Based Health Center or Primary Health Solutions may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
- I have the right to request that School-Based Health Center or Primary Health Solutions restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting to uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

*Please note that the School-Based Health Center is **completely optional**. School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in one of the participating school districts. You may **revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Primary Health Solutions at **(513) 454-1111** or contact your school nurse.

