Cleveland Clinic Children's

LAKEWOOD CITY SCHOOLS

Dear Parent/Guardian:

Lakewood City Schools is teaming up with the Cleveland Clinic Children's Hospital to bring comprehensive healthcare services to your child's school! We have invited Cleveland Clinic Children's to bring its mobile health unit to our buildings because we know good health is essential for learning and cognitive ability. Healthy children learn better.

The healthcare team on the mobile unit can provide well-child examinations, sports physicals, vaccinations, and sick-child visits. Visits to the unit are paid for through your insurance provider. If your child does not have insurance, a Cleveland Clinic financial counselor will contact you to explore assistance possibilities.

To take advantage of this convenient opportunity and to have your child see a licensed healthcare provider on the mobile unit, please completely fill out and sign the enclosed enrollment packet and have your child return it to the Health Center in their school.

Should you have any questions or concerns about this program, please feel free to contact me at 216-227-5129.

Katy Corrigan, RN, BSN, B.S.Ed., MS, LSN
District Nurse
Lakewood City Schools

Jeffrey W. Patterson
Superintendent
(216)529-4092
(216)228-8327-Fax

Executive Offices
1470 Warren Road
Lakewood, Ohio
44107-3997

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Health Data Services, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

216/444-2640
800/223-2273 ext. 42640
Fax: 216/445-7589

Patient Name: _____ Last 4 Digits of Patient's SSN: _____

Date of Birth: _____ / _____ / _____

For the purposes of this form, "my," and "I" mean the patient listed above whose record is maintained by Cleveland Clinic.

I hereby authorize Cleveland Clinic to release any and all health information that is contained in my patient records to the Lakewood City School District for treatment and as otherwise needed for my safety and education at the sole discretion of Cleveland Clinic. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

Once my health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I agree to this authorization. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization form will automatically expire when Cleveland Clinic is no longer providing school-based health care services to the students of the Lakewood City School District, when I am no longer a student of Lakewood City School District, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to: Administrator, Community Pediatrics, Cleveland Clinic Children's, 9500 Euclid Avenue A-11, Cleveland, Ohio 44195.

_____ _____ / _____ / _____

Signature of Patient/Patient's Personal Representative** *(Student can sign if student is over age of 18)* — Date Signed

_____ _____

Printed Name — Relationship, if not Patient

** Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

* If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **must** accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

Cleveland Clinic Children's

School-Based Health Center
Student Parental/Court-Appointed Guardian Notice

ALL AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Cleveland Clinic Children's School-Based Health Center (CCCSBHC).

Student's Name (First & Last)		**Birth Date:**
School District:	**Lakewood City School District**	
School Name:		
Grade:	**Pre K K 1 2 3 4 5 6 7 8 9 10 11 12**	

I acknowledge that my son/daughter/ward named above may receive the following services at the CCCSBHC:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems)
- Pregnancy Testing
- Diagnosis and treatment of sexually transmitted diseases
- Mental Health Assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Cleveland Clinic will bill your insurance company. Any co-pays will be billed. If you are uninsured, a Cleveland Clinic financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the CCCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School-Based Health Center History Form. Controlled prescriptions will need to be picked up directly from the CCCSBHC mobile unit or the nearest designated Cleveland Clinic Children's physician office.

I certify that I have read this notice and understand its contents.

Signature of Parent/Court-Appointed Guardian: _____ **Dated Signed** _____
(Student can sign if student over age of 18)

Relationship to Student: _____

Cleveland Clinic Children's

School-Based Health Clinic History Form

STUDENT NAME _____ **DATE OF BIRTH** _____

(Student 18 years old and older DOES NOT NEED PARENT/GUARDIAN SIGNATURE)

(Please check ✓ all that apply)

ALLERGIES

- ❑ **YES** (Please select below) ❑ **NO ALLERGIES**
- ❑ Food ❑ Seasonal
- ❑ Medications ❑ Animals
- ❑ Insects
- ❑ Reaction: _____

PAST MEDICAL HISTORY

- ❑ Allergies
- ❑ Asthma
- ❑ Ear Infections
- ❑ Gastrointestinal
- ❑ Other (Please list): _____
- ❑ Heart Disease
- ❑ Neurological
- ❑ Behavioral
- ❑ Developmental

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Frequency Taken

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	*Other:* Please list
Alcohol/Drug Abuse	❑	❑	❑	❑	❑	❑	❑	❑	
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	
Anxiety	❑	❑	❑	❑	❑	❑	❑	❑	
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑	
Cancer-Type?	❑	❑	❑	❑	❑	❑	❑	❑	
Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	
COPD	❑	❑	❑	❑	❑	❑	❑	❑	
Depression	❑	❑	❑	❑	❑	❑	❑	❑	
Developmental Problems	❑	❑	❑	❑	❑	❑	❑	❑	
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑	
Gastrointestinal	❑	❑	❑	❑	❑	❑	❑	❑	
Heart	❑	❑	❑	❑	❑	❑	❑	❑	
Hypertension	❑	❑	❑	❑	❑	❑	❑	❑	
Osteoporosis	❑	❑	❑	❑	❑	❑	❑	❑	
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑	❑	
Psychiatric	❑	❑	❑	❑	❑	❑	❑	❑	
Seizures	❑	❑	❑	❑	❑	❑	❑	❑	
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	
Thyroid	❑	❑	❑	❑	❑	❑	❑	❑	

PARENT/LEGAL GUARDIAN SIGNATURE
(Student can sign if student over age of 18) _____ **DATE** _____

Cleveland Clinic Children's
School-Based Health Center
Student – Demographics

TURN OVER
2

Section A: Patient Demographics

First Name:	Middle Name:	Last Name:
Social Security # :	Sex: ❒ Female ❒ Male	Date of Birth: _____/_____/_____ Month Date Year
Mailing Address:		City:
State: / Zip Code:	Home Phone # :	Cell Phone #:
Preferred Language:	Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Multiracial/Multicultural ❒ Native Hawaiian/Pacific Islander ❒ White ❒ Black ❒ Declined Do you identify as Hispanic? ❒ Yes ❒ No	
Name of last doctor seen (If applicable):	Last doctor's phone # Last doctor's fax #:	

Section B: Who is responsible for any medical payments (Guarantor)?

First Name:	Middle Name:	Last Name:
Social Security # :	Sex: ❒ Female ❒ Male	Date of Birth: _____/_____/_____ Month Date Year
Billing Address:		
City: / State: / Zip Code:		Relationship to patient:
Home Phone # :	Cell Phone #: (❒ Same as home?)	Work Phone # :

Section C: Insurance

❒ Yes, I have Medical Insurance	❒ NO, I do not have medical insurance (If no, please include your name, and phone # below in order for a financial counselor to call and discuss options with you further)
Insurance Company Name:	Name:_____
Insurance Product Name (If available)	Phone #:_____
Insurance Product Type (PPO, HMO, POS, etc.):	Name of person on card: (Exactly as it appears)
Subscriber ID #:	Group #: (If listed)

PLEASE INCLUDE A COPY OF THE PARENT/COURT-APPOINTED GUARDIAN IDENTIFICATION (LICENSE) AS WELL AS A COPY

Cleveland Clinic

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

For scanning accuracy, affix patient label within this outlined box

CCF398362

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Cleveland Clinic Hospital and/or its affiliated facilities (each and all of them referred to as "CC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named below) at CC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at CC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my CC caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Financial Responsibility:

1. a. Subject to applicable law and the terms and conditions of any applicable contract between CC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CC for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.

   Or, b. Subject to applicable law and the Cleveland Clinic Health System Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CC for the patient balances due;

And,

2. I authorize the hospital and all clinical providers who have provided care to me, along with any billing services, collection agencies or other agents who may work on their behalf, to contact me on my cell and/or other phone using automatic telephone dialing system or other computer assisted technology.

Assignment of Benefits/ Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: I have received a copy of the Cleveland Clinic Health System Patient Rights and Responsibilities brochure or the Cleveland Clinic Health System Welcome Guide.

Uses and Disclosures of Health Information: I have received Cleveland Clinic Health System's Notice of Privacy Practices. The Notice of Privacy Practices explains how Cleveland Clinic Health System may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Cleveland Clinic Health System use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by CC,

Cleveland Clinic

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

For scanning accuracy, affix patient label within this outlined box.

CCF398362

its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CC or provide assistance to CC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that CC has already relied on my consent.

Teaching Facility/ Clinical Studies: CC is a teaching facility. Doctors and others in training may be involved in my (or the below-named patient's) health care. Many CC patients participate in clinical studies. I can ask my (or the below-named patient's) doctor questions about having health professionals in training involved in the care and about participating in clinical studies, and I can explain any views I have. Clinical studies at CC go through a special process required by law that reviews patient welfare and privacy. CC patients usually consent in writing to participate in clinical studies. Sometimes family members or other surrogates are asked for consent when patients are not mentally able to give their own consent. Patients are encouraged to discuss how they feel about being research participants with family members so they will know the patients' wishes if asked.

Valuables/ Limitation of Liability: I understand that I should not bring valuables (jewelry, money, irreplaceable documents, etc.) with me to CC. I AGREE THAT CC SHALL NOT BE RESPONSIBLE FOR VALUABLES UNLESS THEY ARE DEPOSITED IN THE ADMINISTRATIVE SERVICE CENTER LOCATED IN THE HOSPITAL ADMITTING DEPARTMENT. If I do deposit valuables, CC's LIABILITY IS LIMITED to loss or damage caused by willful or wanton negligence. If I do not deposit valuables, CC is not responsible for them, even if I (or the patient named below) give(s) them to other CC personnel. Items in CC's Lost and Found are given to charity after 30 days.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

X

_____ _____

Signature of Patient or Responsible Party ***Date/Time***

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) ***Responsible Party's Relationship to Patient***

- OR -

Telephone Consent

_____ _____

Printed name of Individual Providing Telephone Consent ***Relationship to Patient***

_____ _____

Witness to Telephone Consent (optional) ***Date/Time***

Cleveland Clinic Children's

Northeast Ohio's Top Children's Hospital*

What is Cleveland Clinic Children's School-Based Health Center?

Cleveland Clinic Children's School-Based Health Center is a mobile, full-service pediatric office staffed with our healthcare professionals. This mobile unit will visit your child's school to provide care regularly throughout the school year as a partnership between your school district and Cleveland Clinic Children's.

Cleveland Clinic Children's mobile health center provides voluntary, comprehensive healthcare services to students in kindergarten through 12th grade. Children who are healthy are best equipped to learn and excel in the classroom. Cleveland Clinic Children's is committed to ensuring that all students receive high-quality, comprehensive healthcare with the added convenience of being at the school where students spend most of their days.

Cleveland Clinic Children's School-Based Health Center can work with your existing healthcare provider in caring for your child. If your child has no primary health care provider, the School-Based Health Center staff may become that provider. If your child needs care when school is closed, you may decide to go to area Cleveland Clinic Children's locations.

*Ranked in 10 out of 10 specialties again by U.S. News & World Report 2014-15.

Cleveland Clinic Children's

What services are provided?

- Complete physical examinations (may be used for sports physicals, camp, college, work authorizations, etc.)
- Comprehensive healthcare, including diagnosis and treatment of acute and chronic illness and reproductive health care
- Health education
- Referral services
- Health screening (vision, hearing, scoliosis, etc.)
- First aid
- Immunizations
- Mental health consultation and referrals

Why is Cleveland Clinic Children's working with school districts?

Cleveland Clinic has an existing relationship with many area school districts, including those districts that are members of the First Ring Superintendents' Collaborative (FRSC). Previous projects include annual BMI screenings, adoption of health and wellness curricula and meal guidelines for school meals.

By engaging students and their families, we will create multiple generations of patients who are better stewards of their own health care improving the population health of the pediatric community and community at large.

How do I pay for school-based care?

If you have insurance, we'll bill your insurance company. Any co-pays will be billed. If you don't have insurance, our financial counselors can help you get insurance for your child. Financial assistance is available for those who qualify.

Who will my child see in the mobile health center?

- A **Cleveland Clinic Children's Pediatrician** or **Pediatric Nurse Practitioner (NP)** will be on site to diagnose and treat illnesses and prescribe medications.
- A **Licensed Practical Nurse (LPN)** or **Medical Assistant (MA)** will assist with healthcare at some sites.

Who would have access to my child's medical records?

All medical records are confidential, as they are part of the Cleveland Clinic medical records system. Before we can share any records, parents/legal gaurdian must sign the *Release Form.*

How can my child receive services?

For your child to receive care, parents/legal guardian must complete the *Release Form* and *Consent to Bill Insurance Form.* After that, your child's enrollment must be updated each year. **If your child does not have a completed School-Based Health Center enrollment on file, your child will not be able to use the program.** Enrollment in the health center is voluntary and can be discontinued at any time. There are no eligibility requirements except that your child currently attends the school district where the School-Based Health Center is located.

To arrange for your child to be seen at the School-Based Health Center, you may call your child's school nurse or our mobile health center staff, or send a note. Parents are welcome and encouraged to accompany their children to the health center. If your child is too ill to attend school and you would like him/her to be seen by our staff, you may call the school nurse or mobile health center to arrange for a same day appointment.

Are school nurse services still available?

Yes, the school nurse will continue to provide your child with the same services, regardless of his or her enrollment in the School-Based Health Center.