LOUISIANA ENROLLMENT/CONSENT FORM
SCHOOL-BASED HEALTH CENTERS (SBHC)

Student's Name: Last	First	Middle Initial	ID# (Office use only.)		
Student's Address (include city):			Zip Code:		
Student's Date of Birth:	Age:	Birth Gender: ❑ M ❑ F	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino		
Race: ❑ Alaska Native ❑American Indian ❑Asian ❑Black ❑Native Hawaiian ❑Other Pacific Islander ❑More than one race ❑White					
Student's Social Security Number:	School:		Student's Grade:		
Preferred Language:	Parent/Guardian Email:		Student's Cell Phone: ( )		
Name of Mother (include maiden name) or Legal Guardian:	Date Of Birth	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Name of Father or Legal Guardian:	Date Of Birth	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Emergency Contact:		Relationship:	Phone: ( )		
Emergency Contact:		Relationship:	Phone: ( )		
Please place a check by your annual household income range listed below:			Household Size:		

□ $ Zero-12,760	□$17,241-21,720	□$26,201-30,680	□$35,161-39,640	□$44,121-48,600	□$53,081-57,560	□$62,041-66,520	□$71,001 – 75,480
□$12,761-17,240	□$21,721-26,200	□$30,681-35,160	□$39,641-44,120	□$48,601-53,080	□$57,561-62,040	□$66,521-71,000	□$75,481-150,960

Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑	Phone: ( )
Name of Student's Dentist: Please check if student does not have a Dentist ❑	Phone: ( )
Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:

Please check the type of health insurance your child has. Please send a copy of insurance card (front and back) to the SBHC.	❑ Medicaid/Healthy Louisiana Plan Name: _____ Plan Number: _____ ❑ Private/Other Insurance Company Name:_____ Company Address:_____ Phone #:_____ Policy #:_____ Group#:_____ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder Social Security #:_____ Does your insurance pay for prescriptions? ❒ No ❒ Yes ❑ No Insurance

Office use only.

Student's Name: _____ 2nd Identifier _____

Does your child have any known allergies to food, medications, insects, etc.? Please list:

If your child does not have health insurance, would you like information on no cost health insurance?

❑ Yes ❑ No

List of current medications student is on with dosage (how much) and how often:

Confidentiality: The School-Based Health Centers (SBHC) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between *the SBHC* and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that *the SBHC* has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at *318-227-3350*. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product**.**

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

Office use only.

Student's Name: _____ 2nd Identifier _____

David Raines Community Health Centers is the health care provider and all decisions relating to the delivery of medical services to students are the responsibility of David Raines Community Health Centers and not the principal, the school nor the school board. All health care center personnel are employees and contractors of David Raines Community Health Centers and are not employees, contractors or agents of the Caddo Parish School Board.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available)♦ telehealth

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that *the SBHC* or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to *the SBHC*.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in *the school* unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

We also understand that the school-based health center is operated by *David Raines Community Health Centers* and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student (optional) Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

STUDENT NAME: _____ DOB: _____ GRADE: _____

Student Medical History (*Please indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies			Speech Problems
		Asthma (Please bring inhaler to clinic)			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor appetite			Other:

Student Surgical & Hospitalization History

Has your child ever had surgery? *(If yes, please specify below)* ❑ Yes ❑ No

Y	N	Surgery	Y	N	Surgery
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Has your child ever been admitted into a hospital? *(If yes, please specify below)* ❑ Yes ❑ No

Hospital	Date	Reason

Family Medical History *(Which of the following medical conditions apply to you or an immediate family member)*

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder				Other:	
		COVID-19				Other:	

Reviewed by: _____ Follow-up planned by: _____

DAVID RAINES COMMUNITY HEALTH CENTERS (DRCHC)
SCHOOL-BASED HEALTH CENTER (SBHC)

Acknowledgement and Understanding of the "Notice of Privacy Practices"

I hereby give consent/permission to the *DRCHC School-Based Health Center (SBHC)* to use and disclose my child's protected health information for the purposes of treatment, payment and health care operations.

I have received a copy of the DRCHC *SBHC* "Notice of Privacy Practices," which provides detailed information about how they may use and disclose my child's protected health information.

By agreeing to the terms provided therein, I will consent to my child's protected health information being shared with a Health Information Exchange.

I understand that:

- I have a right to request a restriction of how his/her protected health information is used and/or disclosed, but the request must be in writing,
- *SBHC* is not required to grant my request, but if *the SBHC* does grant the request, it will be binding.

Student's Name

Signature of Parent or Legal Guardian Date

May 2020

DAVID RAINES COMMUNITY HEALTH CENTERS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THI INFORMAITON. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice describes the privacy practices of David Raines Community Health Centers (Health Centers) and the privacy practices of:

- All of our doctors, nurses, and other health care professionals authorized to enter information about you into your medical record.
- All of our departments, including, for e.g., our Medical Records and Billing Departments.
- All of our Health Centers in Shreveport, Bossier, Gilliam, Minden, and Haynesville, Louisiana.
- All of our employees, staff, students, and other personnel who work for us or on our behalf.

Our Pledge:
We understand that protected health information (PHI) which we will often refer to in this notice as "personal 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 receive. We need this record to provide you with safe, 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 or on behalf of our facilities. It also explains the ways in which we may use and disclose your personal and protected 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.

We are required by law to:

- Make sure that health information that identifies you is kept private in accordance with relevant law.
- Give you the notice of our legal duties and privacy practices with respect to your personal health information.
- Follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Protected Health Information (PHI): We may use and disclose your personal health information for these purposes:

Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the doctors/providers, nurses, assistants, technicians, students and others who are involved in your care. They may work at the office, lab, pharmacy or other health care providers to whom we may refer you for treatment, consultation, x-ray, lab, prescription or other health care services. They may also include doctors and other health care professionals who work at the Health Centers or elsewhere. Some examples of these healthcare services may be a consult with a specialist who lends his/her service to the Health Centers about your care or disclose to an emergency room doctor who is treating you for a broken leg and you have diabetes, because diabetes may affect your body's health process.

Individuals Involved in Your Care or Payment for Your Care: We may release personal health information about you to a friend or family member who is involved in your health care or the person who helps pay for your care. Such individuals should have authorized permission to receive your personal health information. You have the right to request restrictions on our disclosure of your personal health information to someone who is involved in your care.

Required or Permitted by Law: We will disclose personal health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose personal health information about you when necessary to prevent a serious threat to your health and safety, the health and safety of the public or another person. The disclosure will be provided to someone who may provide the appropriate assistance in the prevention of the threat.

De-Identified Information: Parts of your personal health information that does not personally identify you or reveal your identity may be used or disclosed by us.

Public Health Activities: We may disclose personal health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury or disability.
- Report births and deaths.
- Report child abuse or neglect.
- Report reactions to medications or problems with products.
- Notify people of recalls of products.
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect or Domestic Violence: We may disclose parts of your personal health information to appropriate government agencies if we believe you may be a victim of abuse, neglect, or domestic violence and such disclosure is authorized by applicable law or regulation.

Health Oversight Activities. We may disclose personal health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Law Enforcement: We may release health information about you if asked to do so by law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances about the victim of a crime.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at the Health Centers.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information about our patients to a corner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as may be necessary for them perform their duties.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

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, dental and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

You also have the right to inspect and obtain a copy of your personal health information by submitting your request in writing to our privacy contact person identified on the last page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

DAVID RAINES COMMUNITY HEALTH CENTERS
NOTICE OF PRIVACY PRACTICES

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. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to our privacy contact person/designee identified on the last page of this notice. The request must be provided on one page and legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information as follows:

- The information was not created by us, or the person or organization that created the information is no longer available to make the amendment.
- The information is not part of the maintained health record.
- The information is not part of the information which you would be permitted to inspect and copy.
- The information is accurate and complete.

Right to Request Restrictions: You have the right to request certain restrictions or limitations on the personal 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 of your care, such as a family member or friend. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

In most cases, we are not required to agree to your request for restrictions. But if the Health Center agrees to the restrictions, we will comply with your request unless the information is needed to provide you emergency treatment. The Health Center will also agree to restrict disclosure of personal health information about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the personal health information pertains solely to a service for which the individual or a person other than the health plan has paid the health center for in full. A request for restriction must be made in writing to the privacy person listed on the last page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to be notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured personal health information involving your medical and dental information.

Right to Receive Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way. For example, you may ask that we only contact you at work or by mail to a specified address.
If you would like 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 last 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.

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 our privacy contact person identified on the last 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 and revision dates in the footer section on each page, in the lower left-hand corner. We will also give you a copy of our current notice upon request.

Complaints Related to Privacy Notice:
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. You may file a complaint by telephone, mail, fax or e-mail with a written description of your complaint or by telling us about your complaint in person or by telephone. 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.

Brenda Epperson
Privacy Officer
David Raines Community Health Centers
1625 David Raines Road
Shreveport, LA 71107
Phone: (318) 425-2252 Ext. 1121
Fax: (318) 425-2367
Email: bepperson@davidraineschc.org

Or

Compliance
3041 Martin Luther King Drive
Shreveport, LA 71107
Phone: (318) 841-6055
Fax: (318) 222-2979
Email: iedwards@davidraineschc.org

Other Uses and Disclosures of Your Protected Health Information:
Most uses and disclosures of psychotherapy notes, uses and disclosures of personal health information for marketing purposes and disclosures that constitute the sale of personal health information require your written authorization.

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 will keep the information on file.

Rev. 1/2013: Modified 7/2017; 5/2018