Southwest School-Based Health Center
Consent to Treatment Form

418 S. Sligo Street, Cortez, CO 81321
Hours of Operation: Monday-Friday 8:30a-4:30p

Montezuma-Cortez School District RE-1

Please Print
(One Patient/Student per form)

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Consent to Treatment Disclosure

Montezuma-Cortez Schools through Southwest Health System, Inc. (SHS), established a School-Based Health Center (SBHC) program to provide primary care and behavioral health services to its students. Services provided through the SBHC program include, but are not limited to, diagnostic treatment and services, administration of medications, individual, group and/or family therapy, patient education and may include administration of immunizations (immunizations may require a *separate* consent). I voluntarily request and consent to the rendering of health care and behavioral care services by the SBHC, its staff and providers of SHS. I acknowledge that no guarantee can be made or has been made as tothe results of treatments or examinations and I understand that all medical treatments contain inherent risks.

Parental/Guardian involvement and notification. Colorado law may prohibit the SBHC and its providers from informing parents/guardians, without the patient's permission, of mental health problems, substance abuse issues, eating disorders, pregnancy matters, family planning, including birth control and diagnosis or treatment of sexually-transmitted diseases. For the purpose of these conditions, the patient may enter into a confidential and privileged relationship with the SBHC provider. However, it is the SBHC's practice to attempt to gain permission from the patient to inform his/her parent (s), guardian, or a caring adult when one or more of these conditions are present. When permission is not granted, the SBHC staff will strongly encourage the student to communicate their condition to their parent (s) and/or guardian. Parents, guardians, or other authorized representatives with questions about SBHC services are encouraged to contact the SBHC with their inquiries.

Confidentiality and release of information. I hereby authorize the SBHC to release information from the patient's medical records for treatment, payment, healthcare operations and other purposes as permitted by applicable state and federal law, including the Family Educational Rights Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including to any health care provider, the school's nursing staff and other SBHC and RE-1 staff who are involved in any way with the care of the patient and to any person or entity which is or may be liable for all or part of the charges for services, goods, or facilities provided to the patient. I understand that following release of this information, the SBHC cannot control its confidentiality. I also give consent to and authorize the SBHC staff to examine the patient's school records, attendance and other records as necessary to assist the SBHC staff with the patient's diagnosis and treatment. I understand refusal to authorize disclosure of the patient's health information to a health benefit plan (including health insurance companies, discount benefits programs, government health programs, etc.) will have no effect on my enrollment or eligibility for benefits under the SBHC program. I also understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services I receive at this school-based health center, and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients and this data does not specifically identify any individual patient.

Financial responsibility and assignment for direct payment. I hereby authorize the SBHC and its providers to bill any health benefit plan (including health insurance companies, discount benefits programs, government health programs, etc.) that may be responsible for providing coverage and/or payment for services provided to the patient by the SBHC. In the event the patient does not have health care coverage, the SBHC and its providers will provide treatment and services; however, the patient, parent, or guardian must complete a financial eligibility screening to determine if the patient qualifies for any health care assistance programs that help with the cost of the patient's care. I hereby authorize payment to be made directly to the SBHC and its providers, not to exceed the amount of their regular charges, otherwise payable to me for my health care services, goods and facilities provided. I understand there is no guarantee of reimbursement from any health benefits plan or other payer and that I may be financially responsible for all charges not paid for any reason by my health benefit plan or other payer within the time period the SBHC deems reasonable. Co-payments and/or deductibles associated any health benefit plan will be assessed and collected. In addition, it may be necessary to refer the patient to the hospital, specialists, or other health care providers for recommended treatment in order to provide quality health care. These providers may have separate charges for these services which will be the responsibility of the student/parent/guardian and are not covered by this consent form.

Acknowledgement and termination of this consent form. I understand this consent will remain in force until the patient is no longer enrolled in the Montezuma-Cortez RE-1 School District. I also understand that I may revoke this authorization at any time, in writing, except to the extent that the SBHC has already acted on my permission. It is the parent/guardian's responsibility to notify the SBHC about changes in guardianship.

I ACKNOWLEDGE I HAVE READ THIS FORM, UNDERSTAND ITS CONTENTS, AND HAVE RECEIVED A COPY HEREOF. I ACKNOWLEDGE THAT I HAVE REVIEWED MONTEZUMA-CORTEZ SCHOOLS/SHS PRIVACY NOTICE. I FURTHER ACKNOWLEDGETHAT I AM THE PATIENT OR PERSON AUTHORIZED BY THE PATIENT OR OTHERWISE TO SIGN AND ACCEPT THIS AGREEMENTAND CONSENT ON BEHALF OF THE PATIENT.

Signature of Patient, Guardian or Authorized Representative (circle one): ______________________________

Student Signature: ______________________________

Date of Birth: ______________________

Date: ______________________________

Please complete backside of form

Patient Information

Please Print (One Patient/Student per form)

Last Name:____________________ First Name:____________________ MI:________

Date of Birth:____________________ Preferred Name:____________________ Social Security #: ______-______-______

Sex: Male/Female Gender Identity:____________________ Sexual Orientation:____________________

Mailing Address:____________________ City:____________ State:__________ Zip: __________

Physical Address (if different):____________________ City:____________ State:__________ Zip:__________

Home Phone #:____________________ Grade:__________ School: ______________ Email Address:____________________

Parent/Guardian Name:____________________ Date of Birth:____________________

Relationship to Student:____________________ Best Phone #:____________________
(Circle One): Home / Work / Cell

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I have a Primary Care Physician: Yes / No (circle one). If *Yes*, provide details: ____________________

If necessary, to contact you for follow-up care or to confirm an appointment, may we leave a message? Yes / No

Emergency contact person:____________________ Phone #:____________ Relationship to Student:____________________

Preferred Pharmacy: ____________________ Phone #: ____________

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Guarantor
(Person financially responsible to receive statements)

Last Name:____________________ First Name:____________________ MI:____

Mailing Address:____________________ City:____________ State:____________ Zip:____________

Primary Phone:____________________ Work Phone:____________________ Cell Phone: ____________________

Date of Birth:____________________ Social Security #:______-______-______ Relationship to Patient: ____________________

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Insurance Information

Insurance Company:____________________ Policy #:____________________ Group #: ____________________

Primary Subscriber First Name:____________________ Last Name:____________________ MI:____

Mailing Address:____________________ City:____________ State:____________ Zip:____________

Primary Phone:____________________ Work Phone:____________________ Cell Phone: ____________________

Date of Birth:____________ Social Security #:______-______-______ Relationship to Patient: ____________________

I hereby authorize Southwest Health System to furnish information to insurance carriers concerning my illness and treatments. I also assign to the Provider all payments for medical services rendered. I know and understand that any payments rejected by my insurance are between the company and myself, and that I am responsible for any amount not covered by my insurance.

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Ethnicity	**Race**		**Primary Language**
___ Hispanic / Latino	___ American Indian / Alaskan Native	___ Asian	___ English
___ Non-Hispanic / Latino	___ Native American	___ Multiracial	___ Spanish
___ Unknown	___ Black / African American	___ Other	___ Navajo
___ Other	___ Native Hawaiian / Pacific Islander	___ Prefer not to answer	___ American Sign Language
___ Prefer not to answer	___ White		___ Other
			___ Prefer not to answer

Signature of Patient, Guardian or Authorized Representative (circle one): ____________________

Date: ____________________