SCHOOL-BASED HEALTH SERVICES

"A Partner in Student Wellness"

Clarity Healthcare provides primary care and behavioral health services in several school districts in our region. Our School-Based Health Services bring needed care to where kids spend a majority of their day; their school. Our collaboration with school districts helps students to thrive in and out of the classroom environment.

Current School-Based Services

- Acute primary care appointments such as; cough, cold, sore throat, ear infection, rash, warts, and pink eye.
- Strep testing
- Flu testing
- Diabetes management
- Asthma management
- Allergy management
- Well-Child visits
- Sports physicals
- Therapy
- Behavioral health medication management
- Crisis services
- Vaccinations
- Staff education
- Student education

Check with your child's school regarding specific services offered in your district.

Registering for Services

Enrollment paperwork can be obtained at your child's school, on Clarity Healthcare's website or completed electronically (via email).

** Filling out the paperwork does not mean your child will be treated without your consent. You will be contacted prior to any services that are provided to your child.*

Cost

Clarity Healthcare accepts many insurance and provides a sliding fee scale for those without insurance. If a student qualifies for free or reduced lunch at school, there is no out of pocket expense for the services.

FAQ

- A student will not be seen by our provider without parent/guardian consent.
- If your child becomes sick at school, the school nurse will contact you to see if you want your child seen at school.
- You have the option to stay at work, come to the appointment, or join via phone or telehealth.
- The provider can send any prescriptions to your pharmacy.
- The provider will call you with updates after the appointment.

To find out about services offered at your school: **P**: (573) 603-1460 **Ext**: 2326.
To schedule an appointment for therapy services: **P**: (573) 603-1460 **Ext**: 2365.

WEBSITE: www.clarity-healthcare.org
EMAIL: help@clarity-healthcare.org
SPARTAN CLINIC: (660)-225-1188
EMAIL: spartanclinic@pfh.org

Check out The Spartan Clinic Facebook Page! https://www.facebook.com/SpartanClinic

School-Based Health Services

"A Partner in Student Wellness"

Clarity Healthcare/Preferred Family Healthcare School-Based Billing

- If your child has insurance, the insurance will be billed for services.
- A sliding scale is available for those with or without insurance.
- If your child receives free/reduced lunch at school, services are free.
- If you have insurance and your child has free/reduced lunch, your insurance will be billed, but you will not have any out of office expense.
- If you get an explanation of benefits from your insurance, that is not a bill.
- If you get a bill from Clarity and have any questions about it, call our billing department at 573-603-1460, ext. 2380.

Well-visit checks are an important part of a child's overall wellness.

- Well-visit checks help track milestones, growth and development, and social behaviors.
- Well-visit checks are an opportunity for parents to discuss any health concerns they have for their child.
- A well-visit appointment can take place at the school-based health center clinic through Clarity Healthcare.
- Parents don't have to miss work. Parents can call in for the visit, join via telehealth, or be updated by the provider after the appointment.
- To schedule an appointment in Hannibal, call the PATCH Center at 573-719-3247.
- To schedule an appointment in Moberly, call the Spartan Clinic at 660-570-1453.
- Other school districts call 573-603-1460 ext. 2326 to see if this is provided in your school district and to schedule an appointment.

What to expect during a well-child visit

- Determine whether your child has any health concerns.
- Offer ways to keep your child from developing health concerns
- Provide support for your child's overall physical and behavioral health
- Talk through health information, answer your questions, and offer advice

School-Based Health Services
"A Partner in Student Wellness"

Preferred
Family Healthcare

(Please Print)

Today's Date:	Primary Care Provider:		
PATIENT INFORMATION			
Patient Name (Last, First, Middle):	Mr. Ms. Mrs. Miss	Former Name(s):	
Is this your legal name? Yes No	If not, what is your legal name?		
Sex: M F	Birth Date:	Age:	Social Security #:
Primary Phone #:	Secondary Phone #:	Email Address:	
Street Address:	P.O. Box:		
City:	State:	ZIP Code:	
Patient Occupation:	Patient Employer:	Employer Phone #:	
School Currently Attending (If Child):	Does child receive free/reduced lunches: Yes No NA		
Spouse/Guardian/Parent Information:	Address:	Phone #:	
Name:			
Guardian/Parent Information:	Address:	Phone #:	
Name:			
INSURANCE INFORMATION (Please give your insurance card to the receptionist)			
Person Responsible for Bill:	Birth Date:	Address (If different):	Primary Phone #:
Is this person a patient here? Yes No	Patient relationship to subscriber: Self Spouse Child Step-Child Other		
Occupation:	Employer:	Employer Address:	Employer Phone #:
Primary Insurance: Medicare Medicaid Blue Cross Blue Shield United Healthcare Other:________________			
Subscriber Name:	Subscriber SSN:	Birth Date:	Co-Payment:
	Policy #:	Group #:	$
Secondary Insurance (if applicable:	Subscriber Name:	Policy #:	
		Group #:	
Patient relationship to subscriber: Self Spouse Child Step-Child Other			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address):	Relationship to patient:		
Primary Phone #:	Secondary Phone #:		

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of Preferred Family Healthcare DBA Clarity Healthcare. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

Preferred
Family Healthcare

Please check one box in each of the following categories:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	**Primary Language:** ☐English ☐Other (Specify):______________	**Gender Identity:** ☐Male ☐Female ☐Transgender (Female to Male) ☐Transgender (Male to Female) ☐Other ☐Refuse to Disclose	**Sexual Orientation:** ☐Straight ☐Bisexual ☐Lesbian/Gay ☐Don't Know ☐Refuse to Disclose
Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White (not Hispanic or Latino) ☐ Hispanic or Latino (all races ☐ Refuse to Report	**Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated **Are you a Veteran?** ☐Yes ☐No	**Housing Status:** ☐Own/Rent ☐Homeless ☐Transitional Housing ☐Doubling Up ☐Shelter	**Employment Status:** **Patient:** ☐Part ☐Full ☐Unemployed **Spouse:** ☐Part ☐Full ☐Unemployed
How did you hear about Preferred Family Healthcare/Clarity? ☐Referral (Friend/Family) ☐Referral(Physician) ☐Billboard ☐Magazine ☐Newspaper ☐Social Media ☐Health Fair ☐Other (Specify):________________		**Advance Directives:** Do you have an Advance Directive? ☐Yes ☐No If yes, who is your health care agent? ___________________	
Family Members: For the protection of your confidentiality, do you have any family members that work at Preferred Family Healthcare/Clarity? ☐Yes ☐No If yes, who?____			

Insurance and Patient Responsibility: Insurance claims are submitted on your behalf by Preferred Family Healthcare/Clarity. Deductibles and copays are due at the time of check-in. You are responsible for knowing your insurance coverage and if our providers are in-network or not in-network with your insurance plan. For any questions regarding your coverage, we recommend you contact your carrier or plan provider directly. You will need to update or verify personal information at each visit and show your current insurance card. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file or are unable to verify your benefits, you will be considered a self-pay patient. As a self-pay patient, a minimum $50 fee is expected to be paid at the time of service. If you can provide your insurance card and the insurance pays your claim in full, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled.

☐**Assignment of Benefits:** The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Preferred Family Healthcare/Clarity. I understand that I am financially responsible for any balance. I also authorize Preferred Family Healthcare/Clarity or my insurance company to release any information required to process my claims. **(Please acknowledge by checking the box on the left.)**

List ALL members of the household. Include all persons living in the household (related or non-related):

Name:	Relationship:

Preferred Family Healthcare

Sources of Income:

- Wages (W2's, Tax Returns, letter from employer, other)
- Gross Wages/Salaries/Tips
- Unemployment Compensation
- Worker's Compensation
- Earnings from need-based employment programs
- Welfare Benefits
- Social Security
- Supplemental Security Income
- Survivor's Benefits
- Pensions
- Veteran's Benefits
- Regular Contributions from person not living in the household
- Any other income not included in the above list

Total Annual Household Income:	**$**

☐ I have read and completed the attached form and ensure that the information I entered is true and complete to the best of my knowledge. In addition, I have provided verification or provided self-attestation of all household income sources in order for this application to be processed. I understand completion of this form does not guarantee a discount, and if I do not qualify for a discount, I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform Preferred Family Healthcare/Clarity with current documentation of my financial status at my next visit. I also agree to provide updated income verification as often as possible. All information submitted will remain confidential. I understand that if I qualify for the sliding scale program, the minimum due could be a payment of $20 per appointment. **(Please acknowledge by checking the box on the left).**

(For Internal Use Only):

Approved Sliding Scale:	**Staff Signature (if applicable):**

Consent to Treat

The below statements apply to all healthcare providers providing services through Preferred Family Healthcare, Inc. They include services provided by employees, contractors, agencies or other entities affiliated with Preferred Family Healthcare, Inc. Please read each statement carefully and then acknowledge by checking the box to the left. Sign and date the form at the bottom of the page. Be sure that you understand each statement; we will be glad to answer any questions that you may have if you do not understand their meaning.

☐ **Photo Consent:** I give my consent to have a photo taken for office identification purposes. This photo will be kept confidential and stored in my electronic medical record. I understand that having a photo on file is mandatory for programs in which medications are self-administered and failure to do so prevents program participation.

☐ **Notice of Privacy Practices:** I acknowledge that I have been offered a copy of the Notice of Privacy Practices. Per regulatory requirements, a copy of the independent audit report of Preferred Family Healthcare, Inc. is available for review upon request.

☐ **Medications:** I permit Preferred Family Healthcare to store and manage my medications while in the program including prescription, over-the-counter, and those brought on-site. I understand that Preferred Family Healthcare will administer or observe my self-administration of medications. I agree to allow Preferred Family Healthcare or its designated representatives to provide over-the-counter medications such as Ibuprofen, Acetaminophen, Chewable Antacids, and topical medications and pick up medications ordered for me from the pharmacy as well as disposal of medications if they are discontinued by the physician or I leave Against Medical Advice.

☐ **Exercise:** Some Preferred Family Healthcare programs include recreation and physical exercise. I consent to participate in these activities at my own risk. I understand that Preferred Family Healthcare and its representatives shall

not be liable for any claims arising out of participation. If there is a reason I cannot participate, I understand it is my responsibility to notify program staff.

☐ **Release of Information for Billing:** I authorize Preferred Family Healthcare to release medical and billing information for the purpose of payment collection to all parties responsible for payment on my behalf including the entities listed above under insurance information, and Substance Use Disorder funding sources including The Department of Health & Human Services, and the following (as applicable):

Missouri:		Illinois:
•United States Probation & Pretrial Services Western District of Missouri	*•St. Louis Mental Health Board*	*•Adams County Probation*
•Community & Children's Resource Board of St. Charles County	*•Missouri Foundation for Health*	*•Pike County Probation*
•Franklin County Children & Families Community Resource Board	*•Missouri Department of Mental Health*	
•State of Missouri Department of Social Services	*•Office of State Courts Administrator*	**Kansas:**
•Children's Services Fund of Jackson County	*•12th/45th Circuit Treatment Court*	*•United Community Services of Johnson County*
•Jordan Valley Community Health Center	*•9th/41st Circuit Treatment/Drug Court*	
•St. Louis County Children's Service Fund	*•Community Foundation of the Ozarks*	

The information released will be limited to that needed to collect payment and may include release of alcohol or drug abuse (if applicable) information. Authorization includes the release of preadmission, recertification, and appeal information which may include diagnosis, symptoms, treatment plans, test results, or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable). This consent will stay in effect until the account is settled.

☐ **Substance Abuse Records:** I understand substance abuse records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse and can only be disclosed with 1) My written consent 2) A court order 3) To qualified personnel for a medical emergency, research, audit, or program evaluation 4) In reference to a threat or crime committed at the program or against program personnel or as otherwise provided for in the regulations. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. (See 42 USC 290dd-3, 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

☐ **A.R.T. - C:** I understand that I may be given opportunities to participate in the Achieving Recovery Through Creativity (A.R.T.-C) program throughout treatment. I hereby assign, transfer and convey all of my right title and interest in any art I create, in whole or in part, during my participation, to Preferred Family Healthcare, Inc. I understand that photographs and reproductions of my projects may be used as marketing and fundraising materials including but not limited to brochures, newspapers, posters and cards. I understand that no additional consideration will be owed to me for any of these purposes.

☐ **Public/Media Opportunities:** I understand that I may be given opportunities to participate in public contests, shows or community activities which may result in photographs and/or press articles. I may also be given opportunities to be interviewed, photographed and/or videotaped to share my personal story or experiences with Preferred Family Healthcare, for the purpose of creating educational or marketing materials, which may then be distributed broadly throughout the community. Participation in the above-mentioned opportunities may disclose personal information to the public such as my name and hometown as well as my involvement in treatment. Once materials are distributed, there is no guarantee the information will not be picked up by the media or be posted on the internet. Preferred Family Healthcare, it's affiliates, and employees are not legally responsible or liable for the re-disclosure of the information. I understand that these opportunities are in no way mandatory and my voluntary agreement and participation constitutes implicit consent.

☐ **Medical and Psychiatric Advance Directives:** I permit Preferred Family Healthcare, Inc. to obtain emergency medical and/or psychiatric treatment deemed necessary for my physical and mental health unless otherwise specified through written consent. I understand that I will be responsible for payments not covered under insurance benefits for these services. I also give permission to Preferred Family Healthcare and other healthcare entities of which I receive services to share necessary medical information for healthcare and payment purposes.

☐**<u>Communicable Disease Reporting:</u>** I affirm that I do not have current symptoms of any contagious virus or illness such as COVID-19, SARS, or Influenza A/B. I affirm that I do not have a current or recent diagnosis of any such conditions nor have I resided with or been in close proximity to anyone who I have knowledge of having been diagnosed with a contagious illness. Should my health condition change or I become aware of an exposure, I am to report this to my Preferred Family Healthcare provider immediately. I consent to allow Preferred Family Healthcare to report communicable diseases to the Department of Health and Senior Services as outlined by the agency, including cooperation with investigations and providing client information as requested. I acknowledge that Preferred Family Healthcare recommends I wear a mask at all times when present within their facility(ies) and I may opt out. I agree to release Preferred Family Healthcare of any liability should I contract COVID-19, Influenza A/B, SARS, or any other contagious illness.

☐**<u>HIE:</u>** Preferred Family Healthcare/Clarity may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your healthcare providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STI treatment and test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at pfh.org/privacy or you may call us at 1-855-450-5770. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

☐**<u>Telehealth:</u>** I understand that there may be services available to me through participation in Telehealth and that participation in these services is not mandatory and I will be informed of alternative resources for needed care. I can refuse to participate in Telehealth services at any time without affecting my right to future care through Preferred Family Healthcare. Telehealth services are subject to the same confidentiality laws as services provided in person and there will be no dissemination, storage, or retention of video interaction produced during Telehealth services. I will be informed of all parties who are present during the Telehealth service and I have the right to exclude anyone at my request. I will be provided with emergency contact information should a mental health or medical emergency arise.

☐**<u>Alternative Communication Methods:</u>** Preferred Family Healthcare will at times need to communicate with me about my protected health information, the care I receive, my bill, and other services. These communications may include, but are not limited to, refill and appointment reminders, scheduling requests, and referrals. I understand Preferred Family Healthcare may contract with other organizations to manage or collect for the services provided to me. This consent extends to telephone communications by these organizations as well. I understand that use of wireless telephone and email may increase the risk of inadvertent or unauthorized disclosure of my information to third parties. I understand that I am responsible for protecting any information I receive and consent to receive communication through the following **(Please Indicate)**: ☐**Phone call** ☐**Text Message** ☐**Email** ☐**All**

Patient Signature:____ Date:_________________________

Legal Guardian Signature:__________________________________ Date:_________________________

Relationship to patient: Parent Legal Guardian Other (specify):_______________________________
Would you like a copy? ☐Yes ☐No

Medical History Form

Name____Birth Date _____________Date_______

Medications (please list drug name, dose and how often it is taken):

____

____

____

Preferred Pharmacy:____

Allergies (please list any allergies you have and the reaction they cause):

____

____

Are your immunizations up to date? Yes No

If no, what immunizations are missing?____

Tobacco Use: Which best describes you?			
	Current tobacco user Type_______________	How long have you used tobacco?	
	Former tobacco user Type________________	How long did you use tobacco?	
	Never a tobacco user		

Patient History: Have you been diagnosed with any of the following:			
High blood pressure		Heart Disease	
Cancer (type_________________)		Diabetes	
Thyroid disease		Asthma	
Seizure disorder		Stroke	
COPD/Emphysema		Anemia	
Other:		Other:	

Please list any ER visits, hospitalizations or surgeries and approximate date (if known):

____

____

____

____

Family Medical History	
Disease	**Family Member**
Heart Disease Type_______________	
Diabetes	
High Blood Pressure	
Mental Illness Type______________	
Anemia	
Glaucoma/Eye Disorder	
Arthritis	
Stroke	
Seizures	
Thyroid Disease	
Cancer Type_______________	
Kidney Disease	
Other	

Shared Consent to Treat and Record Disclosure for School-Based Services

Clarity Healthcare/Preferred Family Healthcare, Inc.

and

_______________________________________School District

Patient Name:	**DOB:**
Address:	
Phone #:	**Alternate Phone #:**

_____Yes, I consent for the above child to receive health care services through Clarity Healthcare/Preferred Family Healthcare, Inc. via telehealth located at the School District named above.
_____Yes, I consent to allowing the School District named above and Clarity Healthcare/Preferred Family Healthcare, Inc. to share and receive medical and mental health information for the purpose of continuity of care and treatment. I understand that all information exchanged by these persons within these two agencies is confidential and will not be disclosed to any other party without the prior written consent of the parent or legal guardian except as permitted by law. The parent or legal guardian may revoke this release of information at any time by submitting the request in writing to Clarity Healthcare.
_____Yes, I understand that information exchanged by these persons or agencies may be used only for educational, medical, and mental health decisions for the individual child listed above. The above child may not have access to certain services if this release of information is not authorized.

By signing this consent, I confirm I am the parent or legal guardian of the above child, and am authorized to give this consent. I understand I may revoke this consent at any time with a written request.

Signature:	**Date:**

If you would like a copy of this authorization, please initial: _____ Witness Initials:_____

Revised 7/ 2021

Clarity Healthcare/Preferred Family Healthcare, Inc.
Authorization for Disclosure for School-Based Services

Client/Patient Full Name: ____ Date of Birth: _______________

Authorizes **Clarity Healthcare/Preferred Family Healthcare, Inc**. to communicate with, disclose to and obtain from:

Name/Entity: _____________________________
Address: _____________________________
City/State/Zip: _____________________________
Phone: _____________________________
Fax: _____________________________
Purpose of Disclosure: Continuity of Care Legal Insurance Research Individual's Request
Other: ____

The following information contained in my health record:

☐**All records, which will include all of the below**

- ☐Intake Assessment
- ☐Acknowledgement of my admission and/or program participation
- ☐Medication history
- ☐Substance use disorder treatment records
- ☐Progress notes/case notes
- ☐Dates of treatment/discharge summary
- ☐Immunization records
- ☐U.A. or other drug test results
- ☐Physical health information
- ☐Progress toward goals/treatment plans
- ☐Employment verification
- ☐Psychological/Psychiatric information/Mental health evaluation

☐Education records: Grades, Attendance, Behavior (if applicable), Educational Testing, IEP, scales, communication w/teacher and/or counselors

☐STD testing, whether negative or positive, and/or records, which may indicate the presence of communicable, non-communicable, or venereal disease (including but not limited to hepatitis, syphilis, gonorrhea, HIV, or AIDS)

☐Other (please list): ____

This authorization will automatically expire in one year unless there is a different specification of date, event, or condition noted. ____

I understand the following: 1) The purpose and need for such disclosure is for continuity of care. 2)My medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information, whether past, present, or in the future up to the date of expiration or revocation of this authorization. The Protected Health Information in my medical record includes mental/behavioral health information. In addition, it may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other communicable diseases or environmental diseases and conditions. I understand that I may refuse to sign this authorization. 3) If the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by these regulations. 4) I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished per written request and may be specific items or the entire release. 5) I understand that Clarity Healthcare may not generally condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient/guardian or am authorized to act on behalf of the client as the client's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

Patient Signature Date

Parent/Guardian Signature Relation Date

If you would like a copy of this authorization, please initial here______. No copy will be provided if not initialed.