Cleveland Clinic Children's

School-Based Health Care - 216.442.7242

Patient Demographic Form

Grade: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12

Please circle your child's grade above

School District:	**School:**		
Student Name:	**SS#:** ______- ____- ______	**Gender** ____ M ____ F	
Date of Birth: __ /__ /____	**Phone:**	**Other Phone:**	**Preferred Language:**
Address:	**City:**	**State:**	**Zip Code:**

Do you identify as Hispanic? ___Y __N

Race: ___ American Indian/Alaska Native ___ Asian ___Caucasian ___Multiracial/Multicultural ___Native Hawaiian/Pacific Islander ___African American ___Declined

Name of Primary Care Physician (PCP):	**Phone:**

Legal Guardian

Name:	**Date of Birth:** ____ /____ /_______	**SS#:** ________- ______- ___________
Address:	**Phone:**	**Employer:**

Insurance Information

Insurance Plan Name:	**Employer/Group Name:**	
Subscriber Name on Insurance Card:	**Date of Birth:** __ /__ /____	**SS# of Insured:** _______- ______- _________
Group #:	**Subscriber ID#:**	**Employer Address:**

Financial Responsibility: ***If you have insurance Cleveland Clinic will bill your insurance. Copays will be billed. If you are uninsured a Financial Counselor will be contacting you to explore possible assistance options.***

Emergency Contact

Name:	**Phone:**	**Relationship to Patient :**

Services Include:

Comprehensive health inquiry	Routine lab tests
Physical examination (general, sports, pre-employment)	Prescription Medications
Diagnosis and treatment for minor illness and injuries	Care for common pediatric/adolescent physical concerns (weight, acne menstrual problems)
Screening for select health problems (vision, hypertension,etc)	
Care of certain chronic conditions such as asthma and seizure disorder	Pregnancy testing
Immunizations as needed (Tetnus, measles/mumps, rubella, etc.)	Birth control management
Individual health and wellness education services	Diagnosis and treatment of sexually transmitted diseases
Mental health assessments	Follow-up care as needed

After Visit Summary: ***If your child/ward receives services in CCSBHC you/your child will receive an After Visit Summary (AVS) in a sealed envelope.***

Vaccine Information Sheet (VIS) are information sheets *produced by the CDC that explain both the benefits and risks of a* vaccine *to* vaccine *recipients.*
I understand that I will need to acknowledge receipt of the VIS before vaccines are given to the student.

Signature of Parent/Court appointed guardian *____Date _____________ Relationship to Student________________ (Student can sign if student is over the age of 18 years)*

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Clinic History Form

Student Name: | **Date of Birth:** _____/____/______

Allergies	
_____ No known Allergies	_____Yes, Please list below
Medicine	
Insects	
Seasonal	
Animals	
Other	

Past History			
Mark yes for past history	Yes	Mark yes for past history	Yes
Asthma		Heart Disease	
Developmental		Neurological	
Diabetes		If Behavioral list below:	
Ear Infections		Other:	
Gastrointestinal		Other:	

Current Medication

Name of Medication	Dose	Amount per Day	Times per day

Preferred Retail Pharmacy

Name	Address :	Phone#:

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

Family History

Family History	Yes	Family Member (s)	Family History	Yes	Family Member(s)
Alcohol/Drug Abuse			Diabetes		
Allergies			Emphysema		
Anxiety			Gastrointestinal		
Arthritis			Heart		
Asthma			Hypertension		
Breast Cancer			Osteoporosis		
Cancer Type?			Prostate Cancer		
Cholesterol			Psychiatric		
COPD			Seizures		
Depression			Stroke		
Developmental Problems			Thyroid		

Additional information about your child	*Yes*	*Date*	*No*
1. Has your child had a well visit in the last year?			
2. Has your child visited the emergency room in the last 6 months?			
3. Does your child have trouble learning?			
4. Does he or she have an IEP or 504 plan at school?			
5. Do you think your child is being bullied at school?			
6. Does your child have a dentist?			

If your child needs vaccinations at the time of his or her visit, may we complete the needed vaccinations?

Vaccine	*Yes, give*	*No, do not give*	*Vaccine*	*Yes, give*	*No, do not give*
Seasonal Influenza			*Meningococcal MCV4p (Menactra)*		
DTAP			*Meningococcal B (Men-B)*		
Hepatitis A			*Polio*		
Hepatitis B			*Pneumococcal 13 (Prevnar)*		
HIB(Haemophilus inflenza b)			*TD*		
HPV (Human Papillomavirus)			*Tdap (Tetanus, Diptheria, Pertussis)*		
Measles/Mumps/Rubella			*Varicella (Chicken Pox)*		
Meales/Mumps/Rubella/Varicella					

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

School-Based Health Program, Community Pediatrics
Cleveland Clinic Children's
6000 West Creek Drive
Independence, Ohio 44131

Telephone: 216-442-7242

Patient: ____

Last 4 Digits of Patient's SSN: ____________________

Clinic #: ___________________________________

Date of Birth: __________ / __________ / _________

Telephone #:________________________________

Current Address: ______________________________

City: ________________ State: _______ Zip: ________

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 my current school 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 health information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and /or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization form will automatically expire when Cleveland Clinic is no longer providing school-based health care services to the students of my current school, when I am no longer a student of my current school, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, through written notice sent to: Administrator, Community Pediatrics, Cleveland Clinic Children's, 6000 West Creek Drive, Independence, Ohio 44131. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected. The recipient of my health information may be charged for the service of releasing medical information.

If Authorization is not complete, signed, and dated, it may be returned and result in my information not being released until completed

____
Signature of Patient/Patient's Personal Representative**

_________ / _________ / _________
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 (e.g., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

Rev. 9/17/2018

Cleveland Clinic

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

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 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.

I understand that CC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:

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.

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 authorize CC to request a review or file an appeal on my behalf to challenge a determination of benefits or denial of payment made by a third-party payer related to services and care provided. 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, 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.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not

required to receive services from CC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I agree that CC may photograph or record me (or the below-named patient) for the purposes described in CC's Notice of Privacy Practices which I have received. I will be asked to give advance written consent if I can be identified by such photographs or recordings and they are to be used or disclosed outside of CC for a different purpose. I may ask that any such filming or recording be stopped at any time.

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 (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to CC. If I choose to bring valuables 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 in the administrative service center, CC is not responsible for them, even if I (or the patient named below) give(s) them to other CC personnel. I also understand that CC may tell me not to use a valuable at any time. 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

Printed Name of Patient: ________________________________

Signature of Patient or Responsible Party: ________________________________ Date/Time: ________________

Printed Name of Responsible Party (if applicable): ________________________________ Responsible Party's Relationship to Patient (if applicable): ________________________________

PATIENT'S PHONE NUMBER(S)

Home: ________________________________ Mobile: ________________________________

-OR-

TELEPHONE CONSENT

Printed Name of Patient: ________________________________

Printed Name of Responsible Party Providing Telephone Consent: ________________________________ Responsible Party's Relationship to Patient (if applicable): ________________________________

Cleveland Clinic Caregiver Obtaining Telephone Consent: ________________________________ Date/Time: ________________

PATIENT'S PHONE NUMBER(S)

Home: ________________________________ Mobile: ________________________________