Dear Parent or Guardian:

Camden Family Health is currently offering healthcare services to students at your child's school. Services will be available to all students, staff, and community.

We offer the following services: treatment for acute illnesses; follow-up for long term illnesses; laboratory testing; physical exams, including sports physicals and WV Healthcheck physicals; immunizations; health education; referral services for dental, vision, and other specialists; vision, weight, hearing, and blood pressure screenings; and behavioral health services.

Camden Family Health will bill private insurances, Medicaid and the Children's Health Insurance Program (CHIP) for eligible students. Students will not be responsible for payment at the time of service. Parent/Guardian will be billed for copays and/or services not covered by insurance. We do offer a sliding fee discount program for students and adults who qualify.

If you would like for your child to receive services at the Camden Family Health school-based office, please complete and sign the attached consent form and return it to the school office.

If you have any questions concerning the school-based health program, we would love to hear from you directly. Please feel free to stop by or to call us directly.

If you need to reach a provider after normal business hours or when your child's health center is closed, please call (304)226-5725 or (304)872-1663.

Thank You,

Camden Family Health
School-Based Health Center Staff

Camden Family Health
Insurance Information
****Please provide a copy of the card if possible****

_____________________________________ _____________________________
Student's Name (as it appears on insurance card) Date

Private Insurance Information

Insured Parent/Legal Guardian: ____
Birthdate of Card Holder: _________ Social Security Number of Card Holder: ___________________
Address (if different from child): ____
Place of Employment: ____

Insurance Company and Complete Address: ____
____

Insurance Company Phone Number: ____

Group Number: __________________________ Insurance ID Number: _____________________

From (month/year): _____________________ To (month/year): ___________________________

Medicaid Information

Please Circle your child's carrier:

Unicare Aetna Health Plan Other: ______________

Medicaid ID Number: ____
PCP/HMO Provider: ____________________________ Provider Phone Number: _______________

West Virginia Children's Health Insurance Program (WVCHIP)

Please circle your child's carrier:

Unicare Aetna Health Plan Other: ______________

Name listed on card: _____________________________ Birthdate of card holder: ______________
ID Number on card: ______________________________ Group Number: _____________________
From (month/year): _______________________ To (month/year): ___________________________

Please list any additional information on your insurance card.

____

You may send a copy of your card at any time by mail, fax, or drop off.

Camden Family Health School-Based Heath Care Centers

General Consent for Treatment - Assignment of Benefits
Patient Responsibility for **Payment**

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to comprehensive treatment and/or evaluation. I agree to all services offered by the School-Based Health Center and hereby give my consent for my child to receive services at Camden Family Health School-Based Health Center/s.
- Consent to routine testing including but not limited to laboratory work.
- Understand that separate consents will be requested for certain special procedures.
- Authorize the release of any information necessary for processing claims and for the insurance company to pay Camden Family Health.
- I understand that information may be shared with the school nurse or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school and primary care physician to share information with SBHC when pertinent to my child's health.

ASSIGNMENT OF BENEFITS

- Assign all benefits under any insurance, health benefit plan Medicare or Medicaid for payment for medical services rendered by Camden Family Health and further agree to remit payment to Camden Family Health within thirty {30) days of any benefits paid directly to me.

PATIENT RESPONSIBILITY

- Accept financial responsibility for any amount not paid by insurance, other health benefit plans, Medicare, or Medicaid.

TELEHEALTH/TELEMEDICINE

- Consent to telehealth/telemedicine treatment.
- Understand that information about telehealth is available to me upon request as well as being viewable on CFH website.

REQUIRED FORMS

I have received a copy of the "Notice of Privacy Practices," and I understand that it is my responsibility to read the information and ask any questions that I may have. I further understand that current copies are posted in the waiting area and a copy is available upon request.

I understand this document remains in effect until my child's date of graduation unless specifically revoked in writing.

________________________________ ________________________
Student Name and Date of Birth Date

_______________________________ ________________________
Parent or Legal Guardian Signature Date

I, __________________________________, DO NOT want my child ___________________________,
Parent or Guardian Signature Student's Name and Date of Birth

to be seen at the Camden Family Health School-Based Health Center/s.

Camden Family Health
School-Based Health Centers
Parent/Guardian Consent Form

Please read and complete this form so your child can use the School-Based Health Center.

If you want your child to receive health services, please read this form carefully, complete the questions and sign the attached signature sheets.

Name of Student: ____
(Please list child's name as it appears on birth certificate)

____
Parent/Guardian (Please Print) Relationship to child Date

____
Mailing Address City State Zip Code

____________________ ___________________________ ________________________
Home Phone Number Work Phone Number Other Phone Number (Cell)

____
Parent/Guardian (Please Print) Relationship to child Date

____
Mailing Address City State Zip Code

____________________ ___________________________ ________________________
Home Phone Number Work Phone Number Other Phone Number (Cell)

Student's Birth Date: ___/___/_____ Grade: ____ Social Security Number: _____-____-______
(It is very important that we have this number)
Sex (Circle): Male Female Race (Circle): White Black Other: _________________________

Please list an alternate contact: ____________________ Relationship to Child: ___________

Alternate Contact's Phone Number: ______________________

By signing the attached signature sheet, I authorize my child to be seen at the SBHC. I agree to all services offered by the school-based health center and hereby give my consent for my child to receive health services at Camden Family Health School -Based Health Center, operated by Camden on Gauley Medical Center, Inc. I authorize the release of information necessary to process insurance claims and I authorize payment of medical benefits to the health care center. I understand that I am responsible for any charges incurred by my child. I understand that information may be shared with the school nurse and/or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school nurse and/or his/her designee and primary care physician to share information with Camden Family Health when pertinent to my child's health. I understand that this consent will be valid until my child leaves school or until I provide the Camden Family Health staff with written directions otherwise.

Children Will Not Be Seen Without Written Consent
Except as permitted by law

Camden Family Health Student Health History Form

_______________________________________ _____________ ______________________
Student's Name Current Grade Date

The following information will help the healthcare provider evaluate your child's health. Please answer to the best of your knowledge.

Does your child have a family doctor or pediatrician? Yes:____ No:____. If yes, please list your medical provider's Name: _________________________When did your child have his/her last ***complete*** physical exam? ___________

What is your preferred pharmacy for your child? ____
(Pharmacy Name and Location)

____My child has not had a physical exam within the last year. If time allows, I would like my child to get a physical exam during this school year. I understand that I will be notified of the date and time the physical will be given. Afterwards, I will receive a letter explaining the findings and recommendations.

Allergies

Is your child allergic to any medications? Yes____ No____ If Yes, what medications?

Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes____ No____
If Yes, What? ____

Medications

List any Medication your child is currently taking and the reason for which the medication was given.

Medication/Dose	Reason	How long taking medication
_____________________________________	_____________________	_______________________
_____________________________________	_____________________	_______________________

Please check any of the following health conditions that your child has:

___Anemia ___Depressed or overly nervous ___Allergies ___Toothaches
___Asthma ___Frequent Illness ___Hypertension ___Other
___Diabetes ___Scoliosis ___Bladder Infection Please Explain: _______
___Headaches/Migraines ___Seizure Disorder ___Serious Injuries
____
___Emotional Disorders ___Stomach or Intestinal Disorders

Please let us know if your child has other important health issues that we should know about:

Dental

How often does your child go to the dentist? At least once a year: ___ Only with toothaches: ___ Never: ___
When was your child's last dental exam? _________ Name of Dentist: _____________________

Additional Information

In the past year, have there been any changes in your family such as:

___Marriage ___Serious Illness ___Change in School
___Moved to a new home.
___Separation ___Loss of job ___Births ___Divorce
___Deaths ___Other: _______________

*****Please attach a copy of your child's Immunization Record*********

____ ______________________________
Parent/Guardian Signature Date

Version 3/mdr