OMAHA PUBLIC SCHOOLS
School Based Health Services Enrollment and Consent Form
Enrollment is OPTIONAL

Student Information

Student Last Name (legal): Student Number:

First Name (legal): Student Middle Name (full):

Gender: ☐ M / ☐ F Birth Date (mm/dd/yyyy): / /

Home Address: City: Zip:

Grade: Name of School Attending:

Parent/Guardian

Parent Last Name (legal): Parent First Name (legal):

Parent Middle Name (full): Parent Birthdate (mm/dd/yyyy): / /

Parent/Legal Guardian: ☐ Yes ☐ No Relationship to Student:

Home Phone: Work Phone: Cell Phone:

Email: May we text your cell phone number? ☐ Yes ☐ No

School Based Health Centers

School-Based Health Centers (SBHCs) are available in select schools and open to all students. They provide diagnosis, treatment, and prescription services for various illnesses that may keep children out of the classroom. Additionally, SBHCs offer school physicals, immunizations, and behavioral and psychiatric care. Some services may be provided via telehealth, but emergency care is not available.

By signing this enrollment and consent form, you consent to the following:

- **I authorize** Omaha Public Schools staff to share the following student information with OneWorld Community Health Center and Charles Drew Health Center (SBHCs) if services are provided: family and emergency contact details, state student number, attendance records, disciplinary records, schedule, immunization history, health screening results, psychological evaluations, special education (IEP, MDT) records, Section 504 accommodation plans, and information on health conditions (e.g., asthma, allergies, diabetes, seizures).

Health Screenings

In compliance with Nebraska state regulations, students in Early Childhood, Kindergarten, and grades 1, 2, 3, 4, 7, and 10 receive free screenings for hearing, vision, dental, height, and weight. These screenings may be conducted in collaboration with community partners.

Students in grades 5, 6, 8, 9, 11, and 12–where screenings are not state-mandated–may also have the opportunity to receive free vision screenings from Children's Nebraska or other contracted providers.

By signing this consent form, you consent the following:

- **I authorize** my child to receive a vision screening from Children's Nebraska and/or other contracted providers. Additionally, I allow Omaha Public Schools to share the following student information for service provision and program evaluation: family contact details, state student number, schedule, and screening results.

These consents do not apply to grades that are mandated by Nebraska State Law to receive health screenings.

This authorization expires when my child leaves OPS or graduates. I understand that I may revoke this authorization at any time by submitting a letter to the Omaha Public Schools, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024 or by checking the box to revoke below.

School Based ◯ **Yes** ◯ **No** I authorize OPS to release information as described above.

Vision Services ◯ **Yes** ◯ **No** I authorize my child to receive vision services through Children's and/or other contracted service providers as described above. I further authorize OPS to release information as described above.

Parent/Guardian Signature | Relationship to Student | / / Date

Omaha Public Schools does not discriminate on the basis of race, color, national origin, religion, sex (including pregnancy), marital status, sexual orientation, disability, age, genetic information, gender identity, gender expression, citizenship status, veteran status, political affiliation or economic status in its programs, activities and employment and provides equal access to the Boy Scouts and other designated youth groups. The following individual has been designated to accept allegations regarding non-discrimination policies: Superintendent of Schools, 3215 Cuming Street, Omaha, NE 68131 (531-299-0310). The following persons have been designated to handle inquiries regarding the non-discrimination policies: Director of Equity and Diversity (equityanddiversity@ops.org), 3215 Cuming St, Omaha, NE 68131 (531-299-0307).

Office Use Only: ☐ Verified ☐ Programs ☐ Sections Initials

Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

This Box for Staff Use Only:		
Careful Contact:	☐ Yes	☐ No
School-Based:	☐ Yes	☐ No
Barrier: _____		

SCHOOL BASED HEALTH SERVICES (SBHS) PATIENT REGISTRATION & CONSENT TO TREAT

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

PART I: PATIENT REGISTRATION

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): ____/____/____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

Please check which of the following best describes your race. Please only select one:

- ◯ American Indian or Native Alaskan
- ◯ Asian Indian
- ◯ Black or African American
- ◯ Chinese
- ◯ Filipino
- ◯ Guamanian or Chamorro
- ◯ Japanese
- ◯ Korean
- ◯ Native Hawaiian
- ◯ Samoan
- ◯ Vietnamese
- ◯ Other Asian
- ◯ Other Pacific Islander
- ◯ White
- ◯ More than one race
- ◯ Unknown, not listed, or refuse to report

Please check which of the following best describes your ethnicity. Please only select one:

- ◯ Chicano
- ◯ Cuban
- ◯ Mexican
- ◯ Mexican American
- ◯ Puerto Rican
- ◯ Not Hispanic, Latino/a, or Spanish origin
- ◯ Other Hispanic
- ◯ Unreported/Chose not to disclose ethnicity

Please check which of the following best describes your primary medical coverage type. Please select only one:

- ◯ Medicaid
- ◯ Medicare
- ◯ Private or commercial insurance (including through Marketplace)
- ◯ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size	Annual Income Ranges					
1	○ $0-$15,960	○ $15,960.01-$19,949.99	○ $19,950-$23,939.99	○ $23,940-$27,929.99	○ $27,930-$31,920	○ Over $31,921
2	○ $0-$21,640	○ $21,640.01-$27,049.99	○ $27,050-$32,459.99	○ $32,460-$37,869.99	○ $37,870-$43,280	○ Over $43,281
3	○ $0-$27,320	○ $27,320.01-$34,149.99	○ $34,150-$40,979.99	○ $40,980-$47,809.99	○ $47,810-$54,640	○ Over $54,641
4	○ $0-$33,000	○ $33,000.01-$41,249.99	○ $41,250-$49,499.99	○ $49,500-$57,749.99	○ $57,750-$66,000	○ Over $66,001
5	○ $0-$38,680	○ $38,680.01-$48,349.99	○ $48,350-$58,019.99	○ $58,020-$67,689.99	○ $67,690-$77,360	○ Over $77,361
6	○ $0-$44,360	○ $44,360.01-$55,449.99	○ $55,450-$66,539.99	○ $66,540-$77,629.99	○ $77,630-$88,720	○ Over $88,721
7	○ $0-$50,040	○ $50,040.01-$62,549.99	○ $62,550-$75,059.99	○ $75,060-$87,569.99	○ $87,570-$100,080	○ Over $100,081
8	○ $0-$55,720	○ $55,720.01-$69,649.99	○ $69,650-$83,579.99	○ $83,580-$97,509.99	○ $97,510-$111,440	○ Over $111,441

SECTION III: INSURANCE INFORMATION

Insurance Name: _____ Policy Number/Enrollment ID: _____

Group ID: _____ Member ID: _____

SECTION IV: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

How did you hear about Charles Drew Health Center, Inc.? _____

SECTION V: FINANCIAL RESPONSIBLE PARTY INFORMATION

Should match insurance card, if applicable. Only complete this section if the responsible party is different from patient.

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): ___/___/_____

Address: _____ City: _____ State: _____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

Email Address: _____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: ___/___/_____

PART 2: CONSENT TO TREAT

1. **Authorization for Medical Treatment.** I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment, as deemed necessary by Charles Drew Health Center, Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center, Inc. facility will follow the instructions of my provider(s) in the position in said care.
2. **Patient Care.** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.
3. **Personal Valuables.** I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center, Inc. maintains no responsibility for property that is personal and in my possession.
4. **Duration and Scope.** For in-person and telehealth services, I understand this agreement is valid for one year (12 months) from the date it is signed, unless I cancel it sooner. These agreements will apply to any care provided to the patient at any Charles Drew Health Center, Inc. locations during the above-mentioned timeframes, unless the care provided requires additional consents by law.
5. **Physician and Staff Employment.** Some providers at Charles Drew Health Center, Inc. may be independent contractors who use Charles Drew Health Center, Inc. facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill Charles Drew Health Center, Inc. may submit. Contractors are responsible for their own actions and Charles Drew Health Center, Inc. is not liable for their actions or failure to act.
6. **Assignment of Facility Benefits.** I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to Charles Drew Health Center, Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Center, Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicaid and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.
7. **Assignment of Professional Benefits.** I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all physician(s), therapist(s), and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.
8. **Authorized Representative.** I hereby authorize Charles Drew Health Center, Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).
9. **Statement of Responsibility.** I understand that I am financially responsible to Charles Drew Health Center, Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.
10. **Sliding Fee Discount Program Policy.** Charles Drew Health Center, Inc. has a sliding fee discount program and I may ask about it at any time. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request a sliding fee application at any time.
11. **Self-Payment.** I understand I may choose to not have Charles Drew Health Center, Inc. bill my and/or the patient's insurance for a particular health care item or service provided to the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify Charles Drew Health Center, Inc. in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.
12. **Authorization to Release Information to Insurance Company/Third Party Payer.** I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. I understand that information from the telehealth service (including identifiable images or other medical information) cannot be released to researchers or anyone else without my written consent. This Facility will endeavor to protect the confidentiality of my health records, related to in-person and telehealth services. However, the Facility shall not be liable by reason of its release of said health records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed. I also understand I shall have access to all health information resulting from in-person and telehealth services as provided by law.
13. **Non-covered Medicare/Medicaid Services.** The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

14. **Shadowing and Observation.** Some people involved in patient's care may be medical, nursing, or other health care personnel in training. I consent to their participation. Other non-Charles Drew Health Center, Inc. staff members may observe the patient's care. I will be informed of all people who will be present at any site during in-person or telehealth consultations. I will also be informed whether telehealth consultations will be or will not be recorded. I have the right to request that any of these individuals not participate in or observe the patient's care and this request will not affect the patient's care at Charles Drew Health Center, Inc.

15. **Contact by Phone.** By providing Charles Drew Health Center, Inc. with my land line and/or cell phone number(s), I give my express consent for Charles Drew Health Center, Inc., its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages regarding accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

16. **Advanced Instructions for Healthcare.** I understand that I may indicate in writing (Advance Directives, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center, Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Directive statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

17. **Telehealth Consent.** I understand that I have the option to schedule telehealth consultations and may meet with my provider using secure virtual technology. I retain the right to refuse telehealth services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. If I decline telehealth services, in-person care will be provided as an alternative.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Patient Rights and Responsibilities.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Privacy Practices.

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Parent/Power of Attorney/Guardian Signature: _____ Date: ___/___/___

Responsible Party's Signature *(if not the same as patient/parent)*: _____

Insured's Signature: _____ Witness to Signature: _____

Patient unable to sign consent because: _____