Comprehensive Care Center
Parent Consent Form

I hereby verify that I am the parent or legal guardian of_____ I give consent and authorization for assessment/ evaluation/ treatment of the above-named minor by the Comprehensive Care Center (CCC). I am aware that I may contact the CCC if I have any questions or concerns.

I give my consent for primary and preventive physical, and mental health services to be performed by CCC, such as:

- Mental health treatment and assessment; including psychotropic medications.
- First aid and minor emergency care;
- Sport Physicals
- Treatment of health problems (stomach aches, earaches, headaches, cuts, sores, colds, and other problems of that nature);
- Immunizations and vaccinations after consent forms are signed for each immunization;
- Laboratory Services-Skin tests, blood and urine tests to detect things such as anemia (low blood iron), tuberculosis, pregnancy, diabetes, high blood pressure, and other diseases;
- Services related to family life responsibilities, such as counseling regarding adolescent growth and development, personal responsibilities and decision-making;
- Information at Comprehensive Care Center will be reviewed by all medical and mental health professionals.

Student participation is voluntary. I understand that I can refuse any tests, procedures, examinations, and treatments if I so wish. This consent to treatment form will be invalid only for the specific test, procedure, examination, or treatment refused.

Please note that in regards to Psychiatry treatment, consent extends to any medication(s) prescribed.

STUDENT INFORMATION

The following information is required for registration at the Comprehensive Care Center. This information is used to determine eligibility for federal assistance programs that fund the Center. This information is confidential and is treated as a part of the student's medical record. This information will not affect the level of care or treatment by the Comprehensive Care Center.

Patient Name

Street Address **City** **Zip Code**

Home phone number: (____) _____ **Student ID #:**_____

Date of Birth: **Gender:** **Male** ☐ **Female** ☐ **Grade**_____

School: _____

Ethnicity:

Hispanic ☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐

Native Hawaiian/Other Pacific Islander ☐ Other/Multi-Racial ☐

Medical Insurance:_____

Policy/Group# /Member ID#_____

BIN#_____PCN#_____RxGroup#_____

Preferred Pharmacy:_____

Address:_____

SY 20___- 20___

Comprehensive Care Center (CENTRO DE CUIDADOS COMPRENSIVOS)

CONCENTIMIENTO DE EL TUTOR

Por este medio verifico que soy el tutor legal de _____. Doy mi consentimiento y autorización para la evaluación y tratamiento de mi niño por la Clínica de Cuidados Comprensivos (CCC). Estoy consiente que puedo comunicarme con el CCC si tengo cualquier pregunta o duda.

Doy mi consentimiento para que el Centro de Cuidados Comprensivos proporcione a los niños de edad escolar con un amplio ámbito de servicios primarios, físicos preventivos, y salud mental como:

- Tratamiento y evaluación de salud mental incluyendo medicamentos psicotrópicos.
- Primeros auxilios y cuidado menor de emergencia;
- Exámenes Físicos para Deporte
- Tratamientos de problemas de salud;
- Vacunas después de que las formas de consentimiento han sido firmadas;
- Servicios de Laboratorio-Exámenes de la piel, exámenes de sangre y orina para detectar enfermedades como anemia (disminución de glóbulos en la sangre), tuberculosis, embarazo, diabetes, alta presión de la sangre, y otras enfermedades;
- Servicios relacionados con las responsabilidades de la vida familiar, así como consejería referente al crecimiento y desarrollo de los adolescentes, responsabilidades personales y toma de decisiones;
- Educación de salud;
- Informacion de Compreshensive Care Center sera revisada por todo professional medico y de salud mental.

La participación del estudiante es voluntaria. Yo entiendo que puedo negarme a recibir cualquiera de las pruebas, procedimientos, exámenes, y tratamientos si yo así lo deseo. Este consentimiento para tratamiento medico no será válido para la prueba especifica, procedimiento, examen, o tratamiento al que me niegue.

Favor de tener en cuenta que en respect al tratamiento de servicios de psiquiatria, el consentimiento se extiende a medicamento(s) recetados

INFORMACION DEL ESTUDIANTE

La siguiente información se requiere para inscripción en La Clínica de Cuidados Comprensivos. Esta información se usa para determinar si califica para programas federales de donde se sostiene el Centro. Esta información es confidencial y se trata como parte del expediente medico del estudiante. Esta información no afectará el nivel del cuidado o tratamiento dado por La Clínica de Cuidados Comprensivos.

Nombre del Paciente _____

Domicilio _____ **Ciudad** _____ **Zona Postal** _____

Teléfono Casa (___) _____ **Numero del Estudiante** _____

Fecha de Nacimiento _____ **Sexo: Masculino** ☐ **Femenino** ☐ **Grado:** _____

Escuela: _____

Raza:

Hispano ☐ Blanco ☐ Negro/ Afro-Americano ☐ Asiático ☐ Indio Americano ☐

Nativo de Hawaii /o Islas del Pacifico ☐ Nativo de Alaska ☐ Otro/Multi-racial ☐

Servicio Medico: _____

Poliza/Grupo# /Member ID# _____

BIN# _____ PCN# _____ RxGroup# _____

Farmacia Preferida: _____

Domicilio: _____

Number of family members living in your household (please mark one):

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Members of household include self, living at address: (This should include *all persons* related by blood, marriage, or adoption residing in one dwelling.)

1.
Name Age Relationship to Student

Employer Employer's Address Telephone Number

2.
Name Age Relationship to Student

Employer Employer's Address Telephone Number

3.
Name Age Relationship to Student

Employer Employer's Address Telephone Number

4. _____
Name Age Relationship to Student

Employer Employer's Address Telephone Number

5. _____
Name Age Relationship to Student

6. _____
Name Age Relationship to Student

7. _____
Name Age Relationship to Student

8. _____
Name Age Relationship to Student

SY 20___- 20___

Numero de miembros de la familia viviendo en su casa (Marque una):

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Miembros de la familia (incluyase usted) viviendo en el domicilio:
(Esto debe de incluir todas las personas relacionadas por sangre, matrimonio o adopcion viviendo bajo el mismo techo.)

1. _____

Nombre Edad Relacion con el Estudiante

Empleo Domicilio del Empleo Telefono

2.

Nombre Edad Relacion con el Estudiante

Empleo Domicilio del Empleo Telefono

3.

Nombre Edad Relacion con el Estudiante

Empleo Domicilio del Empleo Telefono

4.

Nombre Edad Relacion con el Estudiante

Empleo Domicilio del Empleo Telefono

5.

Nombre Edad Relacion con el Estudiante

6.

Nombre Edad Relacion con el Estudiante

7.

Nombre Edad Relacion con el Estudiante

8.

Nombre Edad Relacion con el Estudiante

I hereby voluntarily consent to and request the treatment rendered to (myself) (my child or dependent) by the physicians/ nurses/ technical assistants and other health care providers of the CCC. I authorize that the CCC give medical attention and treatments to him/her being older than 13 years old and less than 18 years of age without being accompanied by an adult. However, I also acknowledge and accept to abide by the medical decisions of the physicians/nurses/technical assistants and other health care providers of the CCC to allow my son/daughter to be seen without my presence in the event that my presence be a hindrance to their medical evaluation and/or treatment. I accept to accompany him/her if he/she is mentally deficient and is not capable of following doctors' and nurses' instructions or if he/she is disabled.

This consent to medical treatment form encompasses all medical / xray/ nursing / diagnostic procedures, examinations, and treatments (including administration of medications). These porcedures, exaninations, and treatments will be rendered by the medical/ nursing staff of the Comprehensive Care Center as are found to be necessary or desirable in their professional judgement. I acknowledge that no guarantees have been made to me concerning the result of any medcal treatment rendered to (myself) (child or dependent) by the Comprehensive Care Center.

Release of information: The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. 1n compliance with Texas law, my adolescent son or daughter may request that visits and health information remain confidential. I authorize the CCC to disclose all or any portion ofmy child's medical record to his/her primary care provider and other CCC staff; furthermore, the CCC staff may review my child's school records, and other school information that may assist the staff in helping my child.

This consent expires June 30,20___. I understand that it is my responsibility to notify the CCC about changes in guardianship.

C. Signature of Parent/Guardian (or student if over 18) Date Signed

Relationship to Patient

Yo voluntariamente acepto y solicito el tratamiento que se ofrece a mi hijo(a) o dependiente por los doctores, enfermeras, asistentes tecnicos y otros proveedores de salud la Clinica de Cuidados Comprensivos. Yo autorizo que se le de atenci6n medica y tratamientos a el/ ella siendo que es mayor de 13 anos y menor de 18 anos de edad sin ser acompafiado de un adulto. Tambien acepto seguir las sugerencias del medico/ proveedores de la Clinica tocante la decision de atender a mi hijo(a) sin mi presencia ta! y cuando mi presencia sea danino o prevenga la atenci6n medica que mi hijo (a) requiera. Yo acepto acompafiarlo(a) si el/ ella tiene deficiencias mentales y no es capaz de seguir las instrucciones del doctor o la enfermera o si esta incapacitado.

Este consentimiento de tratamiento medicoincluye todos los servicios medicos, rayos X, servicios de enfermeria, diagnosis y procedimientos, examenes y tratamientos (incluyendo administraci6n de medicamentos). Estos procedimientos, examenes, y tratamientos seran proporcionados por el personal medico, enfermeras de la Clinica de Cuidados Comprensivos como sean necesarios o recetados de acuerdo a criterio profesional. Estoy conciente de que no se me ha garantizado nada concemiente a los resultados de ninguno de los tratamientos medicos proporcinados a mi hijo(a) o dependiente por la Clinica de Cuidados Comprensivos.

Dar a conocer informacion: La informaci6n de los registros medicos de mi nifio es confidencial y no se dara a conocer a ninguna persona que no este autorizada, o agencia sin mi consentimiento. En conformidad con la ley aplicable de Texas, mi hijo, o hija adolescente puede requerir que visitas e informaci6n de su salud permanezcan confidencial. Autorizo a la Clinica de Cuidados Comprensivos para revelar toda o cualquier parte de! archivo medico de mi nifio a la persona o institui6n que proporciona sus cuidados de salud y otro personal de! Centro de Cuidado Comprensivos; ademas, el personal de CCC pueda revisar los registros escolares de mi nifio(a), y otra informaci6n escolar que pueda ayudar al personal en ayudar a mi nifio.

LA FORMA DE CONSENTIMIENTO VENCE EN JUNIO 30 DEL 20_. Entiendo que es mi responsabilidad notificar a la escuela acerca de los cambios de tutela.

C. Firma del Padre/ Tutor (Estudiante si es mayor de 18 anos) Fecha

Relacion al paciente :_____

Comprehensive Care Center

Acknowledgement of Receipt of Notice of Privacy Practices
Acuse de Recibo de Aviso de Practicas de Privacidad

I have received a copy of this office's Notice of Privacy Practices.
He Recibido una Copia de este Aviso de las Oficinas de Practicas de Privacidad

_____
Print Name/ Nombre en Letra de Molde

_____
Signature/ Firma

For Our Office Use Only

Our office attempted to obtain written acknowledgement ofreceipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons:

--- Patient refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

--- An emergency situation prevented us from obtaining acknowledgement

____ Other (Describe below)

_____

_____

_____

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent

Required by Law: **We may use or disclose your protected health information when we are required to do so by law.**

Emergencies: **We may use or disclose your protected health information in an emergency treatment situation. Ifthis happens, we will try to obtain your Acknowledgement OfReceipt OfNotice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event ofyour incapacity or an emergency, we will disclose health based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.**

Abuse orNeglect: We may disclose your health information to appropriate authorities ifwe reasonably believe that you are a possible victim of abuse. neglect or domestic violence or the possible victim ofother crimes. We may disclose your health information to the extent necessary to ave11 a serious threat to your health ofsafety or the health and safety ofothers.

Military Activity and National Security: **We may disclose to military authorities the health information ofArmed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody,. the protected health infonnation ofinmates or patients under certain circumstances.**

Required Uses and Disclosures: **Under the law, we must mae disclosures to you and when required by the Secretary ofthe Department of Health and Human Services to investigate or determine our compliance.**

Your Rights:

You have the right to inspect and copy vour protected health information. You have the right to look at or get copies ofyour health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may a form to request access by suing the contact information listed at the end ofthis Notice. We will charge you a reasonable cost-based fee for expenses such, a copies and staff time. You may also request access by sending us a letter to the address at the end ofthis Notice. Ifyou prefer, we will prepare a summary or an explanation ofyour health information for a fee.

You have the right to request a restriction ofyonr protected health information. You have the right to request that we place additional restrictions on our use or disclosure or your health information. We are not required to agree to these additional restrictions, bit ifwe do, we will abide by our agreement, except in an emergency.

You have the right to request alternative communications from us. **You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.**

You have the right to request an amendment to vour health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the **right to receive an accounting of disclosures we have made ofvour** health **information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you. To family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. Ifyou request this accounting more than once in a 12 month period,, we may charge you a reasonable cost based fee, for responding to these additional requests.**

Your have the right to make a complaint about our privacy policies. **Ifyou are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom ofthis page. You may also file a written complaint with the Department ofHealth arid Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department ofHealth and Human Services.**

Y01 1 have the right to obtain a paper copy ofthis notice from us, upon request, even if vou have agreed to accept this notice electronically.

Effective Date: March 01, 2003

Privacy Officer: Michele Doonan, R.N.

Address: 9600 Sims Drive

El Paso, Texas 79925

Telephone: (915) 434-7200

Fax: (915) 434-7217

Notice of Privacy Practices

COMPREHENSIVE CARE CENTER

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If **you have any questions about this Notice, please contact our Privacy Officer.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures or your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure or your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.