

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 review by all medical and mental health

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 invalid only for the specific test, procedure, examination, or treatment refused.

Please note that in regards to Psychiatry treatment, consent extends to any medications(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 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: _____

Comprehensive Care Center (CENTRO DE CUIDADOS COMPRENSIVOS)

CONCENTIMIENTO DE EL TUTOR

Por la presente verifico que soy el padre o tutor legal de _____ I dar Consentimiento y autorización para la valoración/evaluación/tratamiento del menor antes mencionado por el Centro de Atención Integral (CCC). Soy consciente de que puedo ponerme en contacto con el CCC si tengo alguna pregunta o inquietud.

Doy mi consentimiento para que los servicios primarios y preventivos de salud física y mental sean realizados por CCC. como:

- Tratamiento y evaluación de la salud mental; incluyendo medicamentos psicotrópicos.
- Primeros auxilios y atención de emergencia menor;
- Deporte Físico
- Tratamiento de problemas de salud (dolores de estómago, dolores de oídos, dolores de cabeza, cortes, llagas, resfriados y otros problemas de esa naturaleza);
- Inmunizaciones y vacunas después de que se firmen los formularios de consentimiento para cada inmunización¹
- Servicios de laboratorio- Pruebas cutáneas, análisis de sangre y orina para detectar cosas como anemia (bajo contenido de hierro en la sangre), tuberculosis, embarazo, diabetes, presión arterial alta y otras enfermedades;
- Servicios relacionados con las responsabilidades de la vida familiar, como el asesoramiento sobre el crecimiento y el desarrollo de los adolescentes, las responsabilidades personales y la adopción de decisiones;
- La información en el Centro de Atención Integral será revisado por todos los médicos y de salud mental

La participación de los estudiantes es voluntaria. Entiendo que puedo rechazar cualquier prueba, procedimiento, examen y tratamiento si así lo deseo. Este formulario de consentimiento para el tratamiento no será válido solo para la prueba, el procedimiento, el examen o el tratamiento específicos rechazados.

Tenga en cuenta que en lo que respecta al tratamiento de psiquiatría, el consentimiento se extiende a cualquier medicamento (s) prescrito(s).

INFORMACIÓN DEL ESTUDIANTE

La siguiente información es necesaria para registrarse en el Centro de Atención Integral. Esta información se utiliza para determinar la elegibilidad para los programas de asistencia federal que financian el Centro. Esta información no afectará el nivel de atención o tratamiento por parte del Centro de Atención Integral.

_____ **Nombre**
del paciente

Dirección
_____ **Street**

Código postal de la ciudad

Número de teléfono del hogar: _____

Fecha de Nacimiento: _____ **Gender:** Hombre _____ Mujer _____ **Grado** _____

Escuela: _____

origen étnico:

Hispano: _____ **Blanco:** _____ **Negro/Afroamericano:** _____ **Asiático:** _____

Indio americano: _____ **Nativo hawaiano/Otro isleño del Pacífico:** _____

Otros/Multirraciales: _____

decisions of the

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. In 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 of my 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,
guardianship.

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 técnicos y otros proveedores de salud la Clínica de Cuidados Comprensivos. Yo autorizo que se le de atención médica y tratamientos a él/ ella siendo que es mayor de 13 años y menor de 18 años de edad sin ser acompañado de un adulto. También acepto seguir las sugerencias de! médico o/ proveedores de la Clínica tocante **la decisión de atender a mi hijo(a) sin mi presencia ta!** y cuando mi presencia sea dañino o prevenga la atención médica que mi hijo (a) requiera. **Yo acepto acompañarlo(a) si él / ella tiene deficiencias mentales y no es capaz de seguir las instrucciones de! doctor o la enfermera o si está incapacitado.**

Este consentimiento de tratamiento médico incluye todos los servicios médicos, rayos X, servicios de enfermería, diagnóstico y procedimientos, exámenes y tratamientos (incluyendo administración de medicamentos). Estos procedimientos, exámenes, y tratamientos serán proporcionados por el personal médico, enfermeras de la Clínica de Cuidados Comprensivos como sean necesarios o recetados de acuerdo a criterio profesional. Estoy consciente de que no se me ha garantizado nada concierne a los resultados de ninguno de los tratamientos médicos proporcionados a mi hijo(a) o dependiente por la Clínica de Cuidados Comprensivos.

Dar a conocer información: La información de los registros médicos de mi niño es confidencial y no se dará a conocer a ninguna persona que no esté autorizada, o agencia sin mi consentimiento. En conformidad con la ley aplicable de Texas, mi hijo, o hija adolescente puede requerir que visitas e información de su salud permanezcan confidencial. Autorizo a la Clínica de Cuidados Comprensivos para revelar toda o cualquier parte de! archivo médico de mi niño a la persona o institución que proporciona sus cuidados de salud y otro personal de! Centro de Cuidado Comprensivos; además, el personal de CCC pueda revisar los registros escolares de mi niño(a), y otra información escolar que pueda ayudar al personal en ayudar a mi niño.

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

Firma de! Padre/ Tutor (Estudiante si es mayor de 18 años) Fecha

Relación 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 / Firna

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt 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. If this happens, we will try to obtain your Acknowledgement Of Receipt Of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your 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 or Neglect We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed 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 information of inmates or patients under certain circumstances.

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

Your Rights:

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your 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 also request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as, a copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we 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 your 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 of your health information. This right applies to disclosures for purposes other than treatment, payment or health care 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. If you 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.

You have the right to make a complaint about our privacy policies. If you 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 of this page. You may also file a written complaint with the Department of Health and 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 of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: March 01 2003

Privacy Officer: Michele Doonan, R.N.

Address: 300 Vocational Dr.
El Paso Texas 79915

Telephone: (915) 434-7204

Fax: (915) 774-4292

Email: _____ **NIA** _____

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 of 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 or 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.