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 Hospital 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 consent to any request for review or appeal by CC to challenge a determination of benefits made by a third-party payer. 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 hereby consent and grant to CC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by CC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge CC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

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

Signature of Patient or Responsible Party ***Date/Time***

X_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) ***Responsible Party's Relationship to Patient***

_____ _____

Phone Number(s)

Home _____ **Cellular** _____

-OR-

Telephone Consent

Printed Name of Individual Providing Telephone Consent ***Date/Time***

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) ***Responsible Party's Relationship to Patient***

_____ _____

Phone Number(s)

Home _____ **Cellular** _____

Lawson 398362 Rev. 1/16

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Health Information Management/Medical Record Department, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

1- 844-203-8777
Fax: 216-587-8043

Patient Name: _____

Last 4 Digits of Patient's SSN: _____

Date of Birth: _____ / _____ / _____

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 the Cloverleaf Local School District 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 the Cloverleaf Local School District, when I am no longer a student of Cloverleaf Local School District, 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, 9500 Euclid Avenue A-11, Cleveland, Ohio 44195. 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 by law. 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

(Student can sign if student is 18 years or older)

_____ _____

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, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

Cleveland Clinic Children's

School-Based Health Clinic History Form

STUDENT NAME _____ **DATE OF BIRTH** _____

(Please check ✓ all that apply)

ALLERGIES	
❑ **YES**: Please list below ❑ Food: _____ ❑ Medications: _____ ❑ Insects: _____ ❑ Seasonal: _____ ❑ Animals: _____	❑ **NO KNOWN ALLERGIES**

PAST MEDICAL HISTORY	
❑ Allergies ❑ Asthma ❑ Developmental ❑ Diabetes ❑ Ear Infections ❑ Gastrointestinal	❑ Heart Disease ❑ Neurological ❑ Behavioral: Please list _____ ❑ Other: Please list _____

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Times per day

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	*Other:* Please list
Alcohol/Drug Abuse	❑	❑	❑	❑	❑	❑	❑	❑	
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	
Anxiety	❑	❑	❑	❑	❑	❑	❑	❑	
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑	
Cancer-Type?	❑	❑	❑	❑	❑	❑	❑	❑	
Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	
COPD	❑	❑	❑	❑	❑	❑	❑	❑	
Depression	❑	❑	❑	❑	❑	❑	❑	❑	
Developmental Problems	❑	❑	❑	❑	❑	❑	❑	❑	
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑	
Gastrointestinal	❑	❑	❑	❑	❑	❑	❑	❑	
Heart	❑	❑	❑	❑	❑	❑	❑	❑	
Hypertension	❑	❑	❑	❑	❑	❑	❑	❑	
Osteoporosis	❑	❑	❑	❑	❑	❑	❑	❑	
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑	❑	
Psychiatric	❑	❑	❑	❑	❑	❑	❑	❑	
Seizures	❑	❑	❑	❑	❑	❑	❑	❑	
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	
Thyroid	❑	❑	❑	❑	❑	❑	❑	❑	

PARENT/LEGAL GUARDIAN SIGNATURE (Student can sign if student is 18 years or _____ **DATE** _____

older)

Cleveland Clinic Children's

TURN OVER

School-Based Health Center
Student Parental/Court-Appointed Guardian Notice

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Cleveland Clinic Children's School-Based Health Center (CCCSBHC).

Student Name:	**Birth Date:**
School District:	
School:	
Grade:	**Pre K K 1 2 3 4 5 6 7 8 9 10 11 12**

I acknowledge that my son/daughter/ward named above may receive the following services at the CCCSBHC:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical concerns (for example, weight, acne, menstrual problems)
- Adolescent sexual health screenings and management
- Mental Health Assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Cleveland Clinic will bill your insurance company. Any co-pays will be billed. If you are uninsured, a Cleveland Clinic financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the CCCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

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

The Cloverleaf Local School District Board of Education does not render the health care services identified above and is not responsible for damages or claims which arise solely from CCCSBHC's provision of such services.

I certify that I have read this notice and understand its contents.

Signature of Parent/Court-Appointed Guardian: _____ Dated Signed _____
(Student can sign if student is 18 years or older)

Relationship to Student: _____

Cleveland Clinic Children's

School-Based Health Center
Student – Demographics

TURN OVER

Section A: Patient Demographics

Student Name:			
Date of Birth: _____/_____/_____ Month Date Year		Sex: ❒ Female ❒ Male	Social Security # :
Address:			City:
State:	Zip Code:	Home Phone # :	Cell Phone #:
Preferred Language:		Do you identify as Hispanic? ❒ Yes ❒ No	
Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Multiracial/Multicultural ❒ Native Hawaiian/Pacific Islander ❒ Caucasian ❒ African American ❒ Declined			
Name of Primary Care Physician:			

Section B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card:		
Date of Birth of Insurance Holder: _____/_____/_____ Month Date Year		Social Security # of Insurance Holder :
Insurance Holder's Employer and Address:		
Insurance plan name:	Subscriber ID:	Group Name/Number:
Insurance Company Address:		

Section C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name:_____

Phone #:_____

Section D: Emergency Contact Information

Name:			
Address:			
City:	State:	Zip Code:	Relationship to patient:
Home Phone # :	Cell Phone #:		Work Phone # :