Keystone Pediatrics Clinic at Chambersburg Area Senior High School

Dear Parent or Guardian:

Keystone Health and the Chambersburg Area School District collaborated to provide a school-based location of Keystone Pediatrics within Chambersburg Area Senior High School (CASHS). The goal of this clinic is to improve access to quality health care for CASHS students, keeping them healthy and fostering success in school.

Quick Facts: The Keystone Pediatrics Clinic at CASHS is:

- Operated by Keystone Health, a Federally Qualified Health Center and full-service, family-centered, primary care facility with locations throughout Franklin County.
- Open to CASHS students only, during the school year when school is in session from 8:00 AM to 12:00 PM.
- Staffed by licensed and qualified physicians, physician assistants, nurse practitioners and nurses.
- Available to provide your child with all types of physical exams, including sports physicals, treatment of injuries and illness, screenings to test for illnesses, evaluation of behavioral health issues, and developmental assessments.
- Available to be your child's regular healthcare provider, or to support your child's regular doctor/clinic.

Charges: Keystone Health will bill your child's insurance company for services provided at the Keystone Pediatrics Clinic at CASHS. You will be responsible for co-pays and unmet deductible amounts. Keystone Health adjusts its fees based upon patients' ability to pay – no one is turned away due to inability to pay.

Enrollment: Children cannot be treated at the clinic without parent/guardian consent and completion of the forms attached to this letter. In order for your child to receive treatment at the Keystone Pediatrics Clinic at CASHS, please complete the attached forms and have your child return them to the clinic, or you can also mail them to:

Keystone Pediatrics Clinic
Chambersburg Area Senior High School
511 S. 6th Street
Chambersburg, PA 17201

Chambersburg Area School District and Keystone Health believe that this clinic will help make a positive difference in the lives of CASHS students, and we look forward to caring for your child. If you have any questions about the clinic please call us at (717) 709-7900.

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Preauthorization/Consent to Treatment and Assignment of Benefits

Patient/Student Information

Last Name: _____ First Name: _____

Date of Birth: _____ Home Phone: _____

A signed copy of this form is required for Keystone Health to provide routine treatment to the patient/student identified above. If the patient/student identified above is 18 years of age or older, has been pregnant, or has been married, then the patient/student may sign this form on his or her own behalf. Otherwise, this form must be signed by the student/patient's parent or guardian.

Preauthorization/Consent to Treatment

By signing below, I authorize and grant my consent for Keystone Health to provide routine medical treatment to the patient/student identified above at the Keystone Pediatrics Clinic at Chambersburg Area Senior High School. Routine medical treatment includes physical exams, treatment of injuries and illness, immunizations, screenings to test for illnesses, evaluation of behavioral health issues, and developmental assessments, as deemed necessary or advisable by Keystone Health's providers and/or assistants.

I further consent to disclosure by Keystone Health and its related entities of the protected health information of the patient/student identified above to other health care providers as needed for treatment and/or coordination of care.

The consents given above are valid from the date of my signature below until the end of the current school year, unless I revoke them earlier in writing to Keystone Health.

Assignment of Benefits

By signing below, I assign the benefits payable for physician services to Keystone Health, and authorize Keystone Health to submit a claim to the insurance carrier of the patient/student identified above for payment of benefits. In the event the insurance carrier forwards payment directly to me, I will deliver such payment to Keystone Health. I understand that I am financially responsible to Keystone Health for charges not covered by this authorization. I understand that additional charges may be incurred by outside agencies for x-rays, laboratory studies, and durable medical equipment. I authorize Keystone Health to release such information of the patient/student identified above as may be necessary for the completion of insurance claims for services provided by Keystone Health.

Notice of Privacy Practices

I verify that I have been provided with a copy of Keystone Health's Notice of Privacy Practices.

_____ _____

Signature Relationship to Patient/Student

_____ _____

Print Name Date

KEYSTONE HEALTH CLINIC AT CHAMBERSBURG AREA SENIOR HIGH SCHOOL

HIPAA/FERPA AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient/Student Name: _____ Date of Birth: _____

Address: _____ Phone: _____

By signing below, I authorize:

☐ Keystone Rural Health Center to use or disclose certain health information about the patient/student named above to Chambersburg Area Senior High School

☐ Chambersburg Area Senior High School to use or disclose certain health information about the patient/student named above to Keystone Rural Health Center

The type of information to be used or disclosed is as follows: _____

_____

_____

Dates of treatment: _____

The information will be used or disclosed for the following purpose(s): _____

_____

_____

Special Records: Medical records disclosed by Keystone Rural Health Center **will not include** records of drug and alcohol abuse program treatment, mental health treatment, or confidential HIV and AIDS related information **unless the specific boxes below are checked**. Checking the boxes is not a representation that such information exists.

☐ Include Drug and Alcohol Treatment Records (protected by the Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)

☐ Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)

☐ Include AIDS/HIV - Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)

1. This authorization will expire: ☐ Date:_____, or ☐ Event:_____. Unless otherwise specified, this authorization will expire one year after the date of this request.
2. I understand that I have a right to change or revoke this authorization at any time by providing written notification to the party(s) authorized to disclose information above. I understand that revocation will not have any effect on actions taken prior to the revocation.
3. This authorization is voluntary and at my request. I understand that my medical treatment or payment for services will not be affected if I do not sign this authorization.
4. I understand Keystone Rural Health Center and Chambersburg Area Senior High School will not disclose the information they receive from each other pursuant to this consent/authorization without additional prior appropriate consent/authorization. I understand that information provided by Keystone Rural Health Center to Chambersburg Area Senior High School becomes part of the student's educational record, and may no longer be protected by HIPAA if the information is re-disclosed.
5. Keystone Rural Health Center will retain a copy of this authorization in the student/patient's medical record for six years. Chambersburg Area Senior High School will retain a copy of this consent in the student/patient's file.
6. **By signing below, I consent to and authorize the release of the medical information requested, and waive the confidentiality protection afforded by Pennsylvania statutory law for any Special Records identified above.**

_____ _____

Signature of Patient or Patient's Representative/Guardian **Date**

_____ _____

Name of Patient's Representative/Guardian **Relationship to Patient**