PARENT CONSENT FORM

Family HealthCare/Moorhead Schools Health Partnership

FAMILY HealthCare

Medical Services

Family Healthcare is partnering with Moorhead Schools to offer primary care and walk-in services for students and families. The clinic is in the Moorhead High School Career Academy and open to all ages. The clinic follows the school calendar and is open from 8:30am-4:00pm.

Mobile Unit Services

Family Healthcare is continuing to offer mobile dental and optometry services at all Moorhead Schools during the school year. If you consent to these services, Family HealthCare will reach out when the mobile unit is coming to your child's school.

****You will be contacted before any medical or dental appointment occurs.****

Program Consent

Consent for Medical Services - ☐ **Yes OR** ☐ **No**

Consent for Mobile Unit Services - ☐ **DENTAL** ☐ **OPTOMETRY** ☐ **NONE**

Moorhead School your Child Attends: _____

Child's First Name: _____ Middle Name: _____

Child's Last Name (Legal): _____ ☐ Male or ☐ Female

Date of Birth: Month/Day/Year: _____ / _____ / _____

Address: _____ City: _____ Zip: _____

Primary Parent or Guardian's name _____ Phone #: _____

Legal Guardian's primary language: _____ I request interpreting services ☐ Yes ☐ No

Which of the following describes your child? (Check only one) ☐ Black/African American ☐ White ☐ Multiracial ☐ Asian ☐ American Indian/Alaskan ☐ Other _____ ☐ Declined to answer

Which of the following describes your child? (Check only one)

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to answer

Health History

Date of last dental visit:

☐ Within the last 12 months ☐ More than a year ago ☐ Never

☐ Yes ☐ No Is your child allergic to anything? *If yes, what?* _____

☐ Yes ☐ No Is your child taking any medications? *If yes, what?* _____

☐ Yes ☐ No Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, etc.? Or any other medical condition?
If yes, what? _____

Insurance Coverage

☐ I have no insurance and will be paying a fee for service.

Medicaid and other insurance carriers will be billed for services provided. However, I am ultimately responsible for payment for treatment and care. Please fill out insurance information below.

Insurance ID #/Medicaid #: _____ Name of Insurance: _____

Insured Name: _____ Date of Birth: ___ / ___ / ___

Group #: _____

OR Insured Employer: _____ Phone #: _____

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

FAMILY HealthCare

Thank you for choosing Family HealthCare. We are committed to providing you with the highest quality of service and care. We ask that you read and sign this form to acknowledge your understanding of our patient policies.

Patient Acknowledgment and Authorization:

As the patient or patient's guardian,

- I have reviewed the Notice of Privacy that describes the policies of Family HealthCare related to the use of care records and how to get access to this information.
- I understand that Family HealthCare respects patient confidentiality and only releases information in accordance with state and federal law.
- I authorize Family HealthCare to disclose and obtain confidential health information with/from Moorhead Public Schools to coordinate care.
- I authorize Family HealthCare and their providers and staff to provide records acquired during my care to my insurance carrier, third party payers, and other physicians or healthcare entities that participate in my care.

Patient Financial Responsibility:

As the patient or patient's guardian,

- I am ultimately responsible for payment for treatment and care.
- I have provided the most correct and updated insurance information and authorize assignment of payment directly to Family HealthCare and associated entities for all insurance benefits payable or services rendered.
- I understand that I am responsible to pay copayments due at the time of service and amounts for coinsurances, deductibles and non-covered services are due 30 days from receipt of my billing statement.
- I will agree to a payment plan if I am not able to pay the billed balance in full and understand that I may be refused service or sent to collections if I am not willing to pay the for costs of services I have received.
- I realize that certain tests and lab services are sent outside of Family HealthCare and I will be billed separately by the outside entity and these balances are also my responsibility.

Consent for Treatment:

As the patient or patient's guardian,

- I hereby request and authorize Family HealthCare to accept my child as a patient and provide the services and care identified in the course of assessment and evaluation.
- I authorize my child to receive services offered by Family HealthCare, to include but not limited to, exams, x-rays, treatments, diagnostic tests, and medications that any Family HealthCare provider feels is necessary or beneficial to the health of my child.
  - ☐ I consent for my child to receive CDC-recommended vaccines.
  - ☐ I consent for my child to receive the school-required vaccines.
  - ☐ I don't consent for my child to receive vaccines.
- I understand that this form will be a part of my records until such time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

Photo Consent/Release:

- I consent to the use of pictures, videos, or audio recordings of my child for program promotion. ☐ **Yes** ☐ **No**

Financially Responsible/Guarantor Information

Name: _____

Date of Birth: _____

Address: _____

Relationship to patient: _____

Phone Number: _____

Emergency Contact

☐ Emergency contact same as guarantor

Name: _____

Relationship to patient: _____

Phone Number: _____

_____ _____ _____

Printed Legal Guardian Name **Signed Legal Guardian Name** **Date**

FAMILY HealthCare

Access Plan Eligibility

Patient Name: _____ **Date of Birth:** _____

Please circle your family size and income in the chart below.

CIRCLE BELOW Family in Household		Level 1 $30	Level 2 $50/ 70%	Level 3 $60/ 50%	Level 4 $70/ 30%	*Not Eligible*
1	Annual Up To	$15,650	$21,597	$26,605	$31,300	*More than $31,301*
	Monthly Up To	$1,304	$1,799	$2,217	$2,608	
2	Annual Up To	$21,150	$29,187	$35,955	$42,300	*More than $42,301*
	Monthly Up To	$1,762	$2,432	$2,996	$3,525	
3	Annual Up To	$26,650	$36,777	$45,305	$53,300	*More than $53,301*
	Monthly Up To	$2,220	$3,064	$3,775	$4,441	
4	Annual Up To	$32,150	$44,367	$54,655	$64,300	*More than $64,301*
	Monthly Up To	$2,679	$3,697	$4,554	$5,358	
5	Annual Up To	$37,650	$51,957	$64,005	$75,300	*More than $75,301*
	Monthly Up To	$3,137	$4,329	$5,333	$6,275	
6	Annual Up To	$43,150	$59,547	$73,355	$86,300	*More than $86,301*
	Monthly Up To	$3,595	$4,962	$6,112	$7,191	
7	Annual Up To	$48,650	$67,137	$82,705	$97,300	*More than $97,301*
	Monthly Up To	$4,054	$5,594	$6,892	$8,108	
8	Annual Up To	$54,150	$74,727	$92,055	$108,300	*More than $108,301*
	Monthly Up To	$4,512	$6,227	$7,671	$9,025	
9	Annual Up To	$59,650	$82,371	$101,405	$119,300	*More than $119,301*
	Monthly Up To	$4,970	$6,864	$8,450	$9,941	
10	Annual Up To	$65,150	$89,907	$110,755	$130,300	*More than $130,301*
	Monthly Up To	$5,429	$7,492	$9,229	$10,858	

If eligibility is indicated above, a full application and income verification is required to determine approval.
Family Healthcare staff would be pleased to assist with the application process.
Please call 701-271-3344 or speak to a representative for further assistance.

_____ I decline to give my information at this time.

By signing, I understand that Family Healthcare has a sliding fee discount program, and I can apply at any time.

Patient/Legal Guardian Signature **Date**

Legal Guardian Name Printed **Relationship to Patient**

FAMILY HealthCare

Authorization for Medical/Dental Care to Minors or Adults with Disabilities

For families who are ongoing patients of Family HealthCare, it may be more convenient to have prior authorization for medical/dental care delivered to minors/adults with disabilities if for some reason the parent/guardian is unable to be present. Please review the following authorization for treatment and complete the information if you want to pre-authorize treatment.

Authorized person(s) MUST be 18 years of age or older.

Are you the legal guardian(s)? ___Yes ___No (*If not legal guardian, you cannot complete this form)*

☐ I do **NOT** authorize Family HealthCare and its personnel to provide any medical /dental services to my minor/adult without my presence except for in a life -threatening circumstance.

☐ I authorize Family Healthcare and its personnel to deliver medical/dental care to my minor/adult for whom we are the legal responsible party:

Person(s) authorized to accompany minor/adult to clinic if legal guardian is unavailable:

Name: _____ Relationship to child/family: _____

Name: _____ Relationship to child/family: _____

Name: _____ Relationship to child/family: _____

Parent/Legal Guardian Signature

I understand that I am giving permission to Family HealthCare to treat the above-named minor/adult with disability in the event that he/she presents to the clinic with one of the authorized individuals listed above, and that permission is granted to forward pertinent medical or other information from this visit to the insurance company if applicable.

I further understand that parent/guardian must be present for any non-emergent medical/dental surgical procedures including but not limited to tooth extractions and Root Canals. Family HealthCare will do our best to notify guardians of such procedures/paperwork before appointment date.

I understand the above authorization will remain in effect until further written notice is received.

_____

Patient/ Legal Guardian Signature Date

_____

Patient/ Legal Guardian Printed Name