TECHE ACTION BOARD, INC. dba TECHE HEALTH
1115 Weber Street, Franklin, LA 70538
Phone: (337) 828-2550 / FAX: (337) 355-2335
www.techehealth.org

Dear Parent/Guardian/Student:

Please find enclosed a complete school-based health center (SBHC) packet. The SBHC facilities are located in rooms **505** and **506** in West St. Mary High School. Should your child ever need medical and/or behavioral health services, the SBHC staff are happy to provide those services to your student and assist your child in any way. We ask that you please fill out completely the **TECHE HEALTH CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS.** Read carefully the **Explanation of Services and Fees for Services** and all the forms contained in the Packet. Should you have any questions or concerns, please call, or visit the school-based health center at:

Phone: (337) 924-9646 Address: 18333 LA-182, Baldwin, LA 70514

Clinic hours are Monday – Friday, 7:30am – 3:30pm, except for school breaks and other district closures.

The SBHC staff are:

Laura Gros, Physician Assistant
Latosha Bolden, Patient Services Representative (PSR/Front Desk)
Shalonda Provost, Licensed Professional Counselor
Teneka Thomas, Medical Assistant & Phlebotomist

Consent Policy:

Students seeking service/treatment in the SBHC must have written permission from a parent/legal guardian before services are rendered. In accord with the common standards of health care practices, students who require immediate emergency/first aid health care services will be treated until the parent/guardian can be notified and he/she either authorizes continued care or demands the discontinuation of treatment. The signed consent form gives the SBHC permission to provide medical and behavioral health services to the child without contacting the parent/legal guardian each time the child visits the SBHC.

PROCEDURE

1. Parent/Guardian must fill out and sign the SBHC consent form before a student under the age of 18 may receive services.
2. Parents/guardians have a right to indicate the services they will allow or will not allow their child to receive in the SBHC.
3. If a student does not have a signed consent form on file, parents/guardians have the option to visit the SBHC in person to complete and sign the consent for treatment provided by the school-based health center.
4. Verbal consent from a parent/guardian is allowed only 1 time to provide emergency/urgent treatment with the assurance that the parent/guardian will complete and sign a consent form within a brief period of time. The form will be sent home with the student specifying a return date. No further treatment will be provided to the student without a signed consent form on file. Emergency/urgent cases will be referred to appropriate school staff and/or community-based resources.

After-Hours Care Procedures:

To obtain care outside of the normal operating hours of the school-based health center you may use the options below

1. Call your family's primary care provider (i.e., pediatrician, nurse practitioner, general family medicine, etc.)
2. Call the Teche Health clinic(s) within your parish
3. Call 911 for any emergency situation that requires immediate assistance from the police, fire department or ambulance
4. Call 988 (The Suicide & Crisis Lifeline) to be connected to a trained crisis counselor who will help you navigate a mental health and/or substance use crisis or any emotional distress

Service Area:

The SBHC is permitted to serve any student enrolled in the St. Mary Parish School District. Any student and/or a parent/legal guardian may call or visit the SBHC to request a consent packet. School employees, administrators, family members, and community-based providers may call the SBHC to request a **Referral Form** be provided to them via mail, email, or fax.

Teche Health School-Based Health Centers Department Consent Form

SBHC Office Use Only: Account #: _____ Date: _____ Location: West St. Mary SBHC

Please PRINT
Student's Name: _____ Date of Birth: _____
First Middle Last

Student's Mailing Address (include city): _____ Zip Code:

Student's Physical Address (if different, include city): _____ Zip Code:

SS#: | Age: | Sex at birth: ❑ M ❑ F

Gender Identity: ☐Male ☐Female ☐Transgender Male: (Female-to-Male) ☐ Choose not to disclose
☐ Transgender Female: ☐ Other:

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Other: _____
☐ Don't Know ☐ Choose not to disclose

As an FQHC, we are required to ask these questions about the student you are enrolling in the School-Based Health Center. ☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated ☐ Emancipated Minor

Race (mark all that apply) ☐ African American/Black ☐ American Indian/Alaska Native ☐ Caucasian/White
☐ Asian (please specify): ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____ ☐ Refuse to Report

Student's Grade:	School Attending:			
Preferred Language:	Student's Email:		Student's Cell Phone: ( )	
Name of Mother (include maiden name) or Legal Guardian:	Cell Phone: ( )	Work Phone: ( )	Alternate: ( )	Employer:
Name of Father or Legal Guardian:	Cell Phone: ( )	Work Phone: ( )	Alternate: ( )	Employer:
Mother's/Guardian's Email:	Father's/Guardian's Email:			
Emergency Contact Name: 18y/o or over: ☐ Yes ☐ No	Relationship to student:	Phone:		
Emergency Contact Name: 18y/o or over: ☐ Yes ☐ No	Relationship to student:	Phone:		

THIS INFORMATION IS REQUIRED
Student's PCP (Medical Provider/Pediatrician): _____ **( )** NO PCP Phone:

Date of your child's last comprehensive wellness visit: Month _____ Year _____

Student's **Dentist:** _____ Phone:

Date of your child's most recent dental visit: Month _____ Year _____

Preferred Pharmacy:
_____

Are you interested in getting discounted prescriptions from Teche Health Pharmacy:
☐ **Yes** ☐ **No**

Names of siblings enrolled in the School-Based Health Center (print):
1.
2.
3.
4.
5.

Office Use Only:
Student Name: _____ **Date of Birth:** _____

THIS INFORMATION IS REQUIRED	✓**Check the type of health insurance your child has**:
If you are able, please send a copy of the child's insurance card	❑ Medicaid/Bayou Health Plan #: _____ (check one below) ❑ Aetna Better Health ❑ AmeriHealth Caritas ❑ Healthy Blue ❑ Humana Healthy Horizons ❑LA Healthcare Connections ❑ United Healthcare ❑ Private/Other Insurance Name:_____ Policy#:_____ Group#:_____ ❑ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder SSN #:_____ ❑ **No insurance** / Would you like information on health insurance? ❑ Yes ❑ No) **SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY** Your household income and family size may qualify you and your family for a discount on Teche Health services. Our Patient Services Reps (PSRs) and Community Health Workers can assist you with any questions and how to apply ❒ **I WOULD LIKE TO APPLY FOR A SLIDING FEE DISCOUNT**

Collection of the following information is a requirement for Federally Qualified Healthcare Centers.

Are you living in **public housing**? (Section 8 is not considered Public Housing) ❒ Yes ❒ No

How many people live in your home, including you? _____

Head of the household: First & Last Name: _____

Relationship to child:_____ Gender: _____ DOB: _____ Phone Number: _____

Do you lack permanent housing (Are you experiencing homelessness)? • No • Yes, **If yes, check one: ❒ Shelter ❒ Street ❒ Transitional ❒ Doubling Up (living with friends/family)**

❒ Refuse to answer

Approximate monthly household income?

❒ Under $1,000 ❒ $1,000-$1,500 ❒ $1,500-$2,000 ❒ $2,000-$2,500 ❒ $2,500-$3,000
❒ $3,000-$3,500 ❒ $3,500-$4,000 ❒ $4,000-$4,500 ❒ $4,500-$5,000 ❒ $5,000-$5,500
❒ Over $5,500

Other Sources of Income (Mark all that apply)

❒ SSI ❒ Veteran's Assistance ❒ AFDC/TANF ❒ Food Stamps ❒ Social Security
❒ Retirement Benefits ❒ Section 8 Housing ❒ Child Support

1. Is the student a migrant? Has an immediate family member lived away from home in the last 2 years in order to work in any type of agriculture (farm work) ❒ **Yes** ❒ **No**

2. Is a parent, legal guardian, or immediate family member a **seasonal worker** (Has worked in any type of agriculture in the last 2 years, like planting, picking, preparing soil, packing house, driving a truck for any type of farm work, working with animals like cows, chickens, etc.? ❒ **Yes** ❒ **No**

3. Has an immediate family member stopped migrating to work in agriculture because of a disability or age (too old to work)? ❒ Yes ❒ No

4. Does the student have in-home WiFi? ❒ Yes ❒ No

5. Does the student or any immediate family member have a cell phone? ❒ Yes ❒ No;
❒ Android? ❒ iPhone?

6. Does the student or any immediate family member have a federally funded phone? ❒ Yes ❒ No

7. Does the student or any immediate family member have a monthly data plan? ❒ Yes ❒ No

Office Use Only:
Student Name: _____ **Date of Birth:** _____

Is your child **allergic** to any food or medicine? □ Yes □ No Or has seasonal allergies? ❒ No ❒ Yes, If yes, list:

_____

List of **current medications** student is on with dosage (how much) and frequency (how often):

❒ My child takes no medications.

❒ My child takes the following medications: Add an additional page if needed

Medication Name: _____ Dose: _____ Frequency: _____

Medication Name: _____ Dose: _____ Frequency: _____

Is your child experiencing □ Anxiety, □ Depression, □ Alcohol or drug use □ Discipline problems □ Isolation

Does your child currently receive any behavioral health / counseling services? ❒ NO ❒ YES, If yes,

Name of Provider: _____ Phone #: _____

Name of agency: _____ Phone #: _____

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS
BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE ANY OF THE FOLLOWING SERVICES TO YOUR CHILD IF NEEDED

Routine healthcare
Immunizations
Lab draws/diagnostic testing
Prescriptions and Medication administration
Health education and prevention programs
Referral and follow-up for emergencies
Dental services (if available at the SBHC)
Behavioral health/Counseling services/Telehealth
Annual wellness visits (comprehensive physical exam)
Health screenings like vision, hearing, blood pressure
Acute care for minor illness (cold/flu) and injury
Management of chronic diseases like asthma and diabetes
Sports Physicals
Telehealth (Medical)
Referral to specialty care (neurology, orthopedic, psychiatry)

I, as parent/guardian, understand that I will not be charged for any preventative services provided at the West St. Mary School-Based Health Center. I also understand that Teche Health may bill my or my child's insurance plan for all services delivered in the SBHC. I approve payments for authorized services be paid directly to Teche Health.
We (student and parent/guardian) have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

We understand that the school-based health center is operated by Teche Health and its employees and contractors.
We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share protected health information (PHI) with other healthcare providers, entities for treatment, payment, or operations.
We hereby consent to the disclosure of the SBHC's records to the HIEs.
We understand that the SBHC is required to provide information to the Office of Public Health (OPH). Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of the SBHC. We recognize that the information needed by the OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Office Use Only:

Student Name: _____ Date of Birth: _____

CERTIFICATION

I certify that the information given on this form is true and accurate to the best of my knowledge, and I authorize Teche Health to verify this information. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and can bill me for all services received and any services paid by Teche Action Board, Inc. I also certify that I will report any changes in income or insurance status to Teche Health immediately.

PATIENT COMMUNICATION CONSENT

The providers and others here at Teche Health want to do all we can to protect the health information we have about your child's health and keep it private and secure. You have a right to that information, and the right to talk to your healthcare team about it. When we need to contact you, we can only speak to you, or people you have listed below. You should list only the numbers you wish us to use to contact you.

I agree to allow Teche Health to contact me in the following methods regarding my child's private health information, evaluation, and treatment. • If I have checked "YES", I authorize Teche Health to leave messages for me when I am unavailable.

Home Phone _____ ☐ YES ☐ NO **Cell Phone** _____ ☐ YES ☐ NO

Work Phone _____ ☐ YES ☐NO Other Phone _____ ☐ YES ☐ NO

I authorize Teche Health and medical staff to discuss my child(ren)'s healthcare information (which may include history, diagnosis, labs, test results, treatments, and other health information) with the contacts listed below. I understand that by leaving spaces blank, I am indicating my choice to be "No Information," and I do not want any information released without my express consent.

Name: _____ **Relationship to Patient:** _____ Contact Info: _____

By my signature below I acknowledge that I have read and.understand the information provided in this form above and authorize services by Teche Health as the patient or as the patient's general agent and accept its terms. I understand the risk associated with the **different methods of communication, and consent to the conditions, restrictions, and the patient responsibilities outlined above as** well as any other instruction that Teche Health may impose. I understand that I will be required to update this information at least **annually or when my information changes, whichever occurs first.**

It is in your best interest and in the best interest of Teche Health that Behavioral Health providers do not/will not communicate with any parents, caregivers, or patients regarding the treatment or care provided via email and/or text. Nor will we initiate communication with you as a parent, caregiver, or patient in this manner.

Louisiana Law R.S. 40:31.3 states that: **Health centers in schools are prohibited from:**
(1) Counseling or advocating abortion in any way or referring any student to any organization for counseling or advocating abortion.
(2) Distributing at any public school any contraceptive or abortifacient drug, device, or other similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs devices, or other similar products, contact the **Adolescent School Health Program at the Office of Public Health at 504.568.3504.**

Confidentiality: The School-Based Health Center (SBHC) adheres to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA).

By signing below I attest that:

- **I consent to the exchange of relevant protected health information (PHI) between the West St. Mary SBHC and the student's pediatrician and/or personal medical provider(s), or specialist provider(s).**
- I have been given a copy of Teche Health's ***Notice of Privacy Practices and Patient's Bill of Rights and Responsibilities*** that describes how my health information is used and shared. I understand that Teche Health has the right to change this Notice at any time and that I may obtain a current copy by contacting the School-Based Health Center, at **(337) 924-9646.**

This consent may be withdrawn or modified at any time by written notice of the parent/guardian and/or student to any of the entities referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

CONSENT SIGNATURES

✓_____

Name of Parent/Legal Guardian (Print and Signature) **Relationship to Student** **Date**

✓_____ _____

Name of Student (Print and Signature) **Date**

✓_____ _____

Name of SBHC Witness (Signature) **Date**

Teche HEALTH

School-Based Health Centers Department

INITIAL HISTORY QUESTIONNAIRE

Patient Name _____ **Birth Date:** _____ **Age:** _____ ☐ **Female** ☐ **Male**

Person completing the form _____ **Date Completed:** _____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live: _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody

☐ Lives with foster family ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

Birth History Unknown

Birth Weight _____ Was the baby born at term? ☐ Yes ☐ No _____ Weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain

Was a NICU stay required? ☐ Yes ☐ No Explain

During pregnancy, did mother:

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Initial feeding ☐ Formula ☐ Breast Milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain

General

DK Do Not Know

Do you consider your child to be in good health?	☐ Yes	☐ No	☐ DK	Explain
Does your child have any serious illness or medical conditions?	☐ Yes	☐ No	☐ DK	Explain
Has your child had any surgery?	☐ Yes	☐ No	☐ DK	Explain
Has your child ever been hospitalized?	☐ Yes	☐ No	☐ DK	Explain
Is your child allergic to medicine or drugs?	☐ Yes	☐ No	☐ DK	Explain
Do you feel your family has enough to eat?	☐ Yes	☐ No	☐ DK	Explain

Biological Family History

Have any family members had the following?

Childhood Hearing Loss	☐ Yes	☐ No	☐ DK	Who	Comments	
Nasal Allergies	☐ Yes	☐ No	☐ DK	Who	Comments	
Tuberculosis	☐ Yes	☐ No	☐ DK	Who	Comments	
Heart Disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments	
High Cholesterol/Takes Cholesterol Medication	☐ Yes	☐ No	☐ DK	Who	Comments	
Anemia	☐ Yes	☐ No	☐ DK	Who	Comments	
Bleeding Disorder	☐ Yes	☐ No	☐ DK	Who	Comments	
Dental Decay	☐ Yes	☐ No	☐ DK	Who	Comments	
Cancer	☐ Yes	☐ No	☐ DK	Who	Comments	

Biological Family History *(continued from front side)*

DK = Do Not Know

Liver Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Kidney Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Obesity	☐ Yes	☐ No	☐ DK	Who		Comments	
Epilepsy or Convulsions	☐ Yes	☐ No	☐ DK	Who		Comments	
Alcohol Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Drug Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Mental Illness/Depression	☐ Yes	☐ No	☐ DK	Who		Comments	
Developmental Disability	☐ Yes	☐ No	☐ DK	Who		Comments	
Immune Problems, HIV or AIDs	☐ Yes	☐ No	☐ DK	Who		Comments	
Tobacco Use	☐ Yes	☐ No	☐ DK	Who		Comments	

Additional Family History _____

Past History

DK = Do Not Know

Does you child have, or has your child ever had:

Chickenpox	☐ Yes	☐ No	☐ DK	When	
Frequent Ear Infections	☐ Yes	☐ No	☐ DK	Explain	
Problems with Ears or Hearing	☐ Yes	☐ No	☐ DK	Explain	
Nasal Allergies	☐ Yes	☐ No	☐ DK	Explain	
Problems with Eyes or Vision	☐ Yes	☐ No	☐ DK	Explain	
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	☐ Yes	☐ No	☐ DK	Explain	
Any Heart Problem or Heart Murmur	☐ Yes	☐ No	☐ DK	Explain	
Anemia or Bleeding Problem	☐ Yes	☐ No	☐ DK	Explain	
Blood Transfusion	☐ Yes	☐ No	☐ DK	Explain	
HIV	☐ Yes	☐ No	☐ DK	Explain	
Organ Transplant	☐ Yes	☐ No	☐ DK	Explain	
Malignancy/Bone Marrow Transplant	☐ Yes	☐ No	☐ DK	Explain	
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain	
Frequent Abdominal Pain	☐ Yes	☐ No	☐ DK	Explain	
Constipation Requiring Doctor Visits	☐ Yes	☐ No	☐ DK	Explain	
Recurrent Urinary Tract Infections and Problems	☐ Yes	☐ No	☐ DK	Explain	
Congenital Cataracts/Retinoblastoma	☐ Yes	☐ No	☐ DK	Explain	
Metabolic/Genetic Disorders	☐ Yes	☐ No	☐ DK	Explain	
Cancer	☐ Yes	☐ No	☐ DK	Explain	
Kidney Disease or Urologic Malformations	☐ Yes	☐ No	☐ DK	Explain	
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain	
Sleep Problems; Snoring	☐ Yes	☐ No	☐ DK	Explain	
Chronic or Recurrent Skin Problems (e.g., acne, eczema)	☐ Yes	☐ No	☐ DK	Explain	
Frequent Headaches	☐ Yes	☐ No	☐ DK	Explain	
Convulsions or Other Neurologic Problems	☐ Yes	☐ No	☐ DK	Explain	
Obesity	☐ Yes	☐ No	☐ DK	Explain	
Diabetes	☐ Yes	☐ No	☐ DK	Explain	
Thyroid or Other Endocrine Problems	☐ Yes	☐ No	☐ DK	Explain	
High Blood Pressure	☐ Yes	☐ No	☐ DK	Explain	
History of Serious Injuries/Fractures/Concussions	☐ Yes	☐ No	☐ DK	Explain	
Use of Alcohol or Drugs	☐ Yes	☐ No	☐ DK	Explain	
Tobacco Use	☐ Yes	☐ No	☐ DK	Explain	
ADHD/Anxiety/Mood Problems/Depression	☐ Yes	☐ No	☐ DK	Explain	
Developmental Delay	☐ Yes	☐ No	☐ DK	Explain	
Dental Decay	☐ Yes	☐ No	☐ DK	Explain	
History of Family Violence	☐ Yes	☐ No	☐ DK	Explain	
Sexually Transmitted Infections	☐ Yes	☐ No	☐ DK	Explain	
Pregnancy	☐ Yes	☐ No	☐ DK	Explain	
(For girls) Problems with Periods	☐ Yes	☐ No	☐ DK	Explain	

Has had first period? ☐ Yes ☐ No Age of first period _____

Any Other Significant Problem _____

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Phone: (337) 828-2550 / FAX: (337) 828-2873
www.tabhealth.org

EXPLANATION OF SERVICES AND FEES FOR SERVICES
TECHE HEALTH – WEST ST. MARY HIGH SCHOOL-BASED HEALTH CENTER

Teche Health has partnered with the St. Mary Parish School District to offer healthcare services in the **West St. Mary High School-Based Health Center (SBHC).** Teche Health has an agreement with the St. Mary Parish School Board to provide quality, comprehensive, preventative, primary healthcare services to the students, faculty, and staff of West St. Mary High and B.E.B Middle Schools and other students enrolled at most schools in the St. Mary Parish school district. This notice includes information about the SBHC and its services, and enclosed are the Consent Form and documents required should you choose to enroll your child/children in the school-based health center. Enrolling your child in the SBHC does not replace their current Pediatrician or primary care provider. We work collaboratively will your child's provider.
Please keep this letter and refer to it when you need to. If you have any questions, please contact Karla Vappie, the SBHC Director at (337) 828-2550, ext. 2236.

Pursuant to Federal law, Teche Health is not permitted to provide free services or waive or reduce patient co-pays/deductibles without proper documentation showing the patient is eligible for a Sliding Fee Discount. If you are interested in applying for a Sliding Fee Discount, please indicate this on your consent form and provide the necessary information to determine eligibility.

The SBHC must have parental consent prior to enrolling a student as a patient. A parent or legal guardian **must sign** the **Consent Form** and any center-specific forms that require signature for the student to receive SBHC services. Once a parent/guardian signs these forms, the SBHC will provide services that the child needs or will refer to another provider as needed. The SBHC will attempt to keep parents informed of the services their child receives, however, signing the Consent Form gives the SBHC permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the SBHC. No child is treated, counseled, or referred elsewhere without a consent form signed by parent, but the SBHC is required by law to treat the child even if the parent cannot be reached prior to the treatment.

The SBHC is staffed with a medical provider, nursing staff, and a behavioral health provider who will provide care to students. All staff members are licensed and/or certified professionals according to their job function. They work to keep your child healthy, in school and ready to learn. Feel free to call or visit the SBHC if you have questions at **(337) 924-9646**.

The services provided in the SBHC are the same as those provided in any physician's, nurse practitioner's, or physician assistant's medical office, and we follow the Louisiana Medicaid/EPSDT and the American Academy of Pediatrics (AAP) recommendation that certain preventative healthcare services be provided at certain ages because they help prevent illness and keep children healthy. You may visit https://www.aap.org/periodicityschedule for the **Recommendations for Preventive Pediatric Health Care—Periodicity Schedule**

The SBHC staff WILL NOT collect any co-pays or deductibles directly from students who present without a parent. Parents/Guardians will not be billed for any out-of-pocket costs for services provided at the West St. Mary School-Based Health Center. The Teche Health SBHC will send a **bill** to the insurance plan(s) that are listed on the consent form. Families who do not have insurance will receive information on how to apply for health insurance.

If a staff or faculty member presents, the SBHC will collect the required co-pays or deductibles from them, after applying any eligible sliding discount. If they cannot pay at time of service, they will receive a bill in the mail for the balance they still owe, and Teche will bill the insurance plan.

The SBHC will provide the following preventative services to students at "no charge" because insurance plans specifically cover these services at no cost to their members:

- **Well child check-ups** in which the staff will:
  - measure student's height and weight
  - check if child weighs too much, too little, or are within normal range for their age and height
  - take blood pressure
  - draw blood or collect urine to be sure child does not have anemia, high blood sugar, lead poisoning, or other problems
  - test vision and hearing
- **Immunization**s – students can get their shots at the SBHC

All "non-preventative" services listed will result in a bill being sent to the insurance company and to the family for any patient responsibility costs after any eligible slide discount is applied. If the SBHC refers the client outside of the center to another medical provider for a test or procedure that cannot be performed in the SBHC (i.e., X-rays, certain laboratory tests, etc.), families may get a bill from that provider.

Primary and preventive health care/comprehensive history and physical exam include:

- Well child check-ups where the staff will:
  - Measure students' height and weight
  - Check if they weigh too much, too little, or are just right for their age, weight, and height
  - Take their blood pressure
  - Draw some blood or collect some urine to be sure they do not have anemia, high blood sugar, lead poising, or other problems
  - Test their vision and hearing
- Immunizations – students can get their shots at the SBHC
- Nutrition- the staff will talk to students about health eating habits including eating good foods (like fruits and vegetables), and avoiding or limiting junk food
- Health education- the staff will talk to students about doing healthy things like using a bike helmet and seat belts and getting exercise. They will also ask about unhealthy habits that have caused students to be sick and if they need medicine to help. The staff will talk to them about stopping these unhealthy habits and how to get help to stop them.
- Comprehensive history means that the staff will ask students and/or parents about:
  - Past and current health
  - Past illnesses or times spent in the hospital
  - Any allergies to medicines
  - Diseases that run in the family, like high blood pressure or high blood sugar
  - Using tobacco, alcohol, or drugs
  - Feeling sad, depressed, and angry
  - Sexual behavior
- A physical exam means that the staff may ask a student to get undressed and put on a hospital gown or sheet. Then the staff will check all body systems to be sure that the student is healthy in all areas. This is the same thing that would happen in a medical office.

Services for sexually transmitted infections (STI) and HIV/AIDS:

- Students who are engaging in sexual activity may get infections that they do not know they have. These infections can make them sick and can make the person they are having sex with sick. If a person does not take medicine, some of these infections can cause a person to not be able to have children. Some people who have not gotten medicine have died from STIs. The staff at the health center can test students for these infections and can give students medicine to get rid of infections if they have any. The staff will talk to students about not continuing to have sex and not giving STIs to other people.
- The staff can also test students to see if they have HIV/AIDS. Medical providers want everyone age 13 and older be tested for HIV/AIDS whether they are having sex or not. If a student does have HIV/AIDS, they will be referred immediately to a doctor specializing in the care of this disease.

Chronic disease management:

- If students have diseases like asthma or diabetes, the staff can help them stay on their medicines and help them if they get sick at school. The staff can also help students learn how to live with their illnesses without getting sick as often.

Acute/ emergency care for minor illness and injury and referral for serious illness or injury:

- The staff can provide care for cuts, headaches, colds, or other short-term problems
- The staff can manage emergency situations, like accidents on the campus
- The staff will be sure students get help from another practitioner or hospital if the SBHC cannot provide all the services the students need.

Behavioral Health services:

- The counselor conducts a risk assessment to assist in addressing the risk behaviors impacting health, well-being, and academic success in youth.
- The counselor talks to students about healthy coping skills
- The counselor talks to students about staying away from or stopping risky behaviors like using alcohol and/or drugs, smoking, vaping, sexual activity
- The counselor teaches students how to make good decisions
- The counselor helps students overcome feelings of sadness/depression, grief and anxiety
- The counselor works with students by themselves or in groups on anger control, expressing emotions in healthy ways

SLIDING FEE DISCOUNT

As a Federally Qualified Health Center, Teche Health offers a **sliding fee discount** to all uninsured and underinsured individuals who qualify based on an approved **sliding fee scale**. This Sliding Fee Scale is based on the United States Department of Health and Human Services (HHS) Federal Poverty Guidelines and uses household size and income to determine eligibility. The Federal Poverty Guidelines assist Teche Health in assessing eligibility for individuals living at or below Federal Poverty Level (FPL). Teche Health offers 4 distinct categories (A, B, C, and D) of discount eligibility, with Category A patients begin assessed a nominal fee for services.

In order to apply for a Sliding Fee Discount, a patient **must** provide household size and proof of total household income at the time of service. Once eligibility is established, the patient's charges may be discounted down to only a nominal fee. All patients must submit proof of income each year, or more frequently depending on circumstances, in order to continue receiving discounted services.

2024 HHS FEDERAL POVERTY GUIDELINES
100% at or below FPL

Number of Persons in Family	Income Guidelines 100% and below FPL Category A	Income Guidelines 101 – 135% above FPL Category B	Income Guidelines 136 – 170% above FPL Category C	Income Guidelines 171-200% above FPL Category D
1	**$15,650**	**$21,128**	**$26,605**	**$31,300**
2	**$21,150**	**$28,553**	**$35,955**	**$42,300**
3	**$26,650**	**$35,978**	**$45,305**	**$53,300**
4	**$32,150**	**$43,403**	**$54,655**	**$62,400**
5	**$37,650**	**$50,828**	**$64,005**	**$75,300**
6	**$43,150**	**$58,253**	**$73,355**	**$86,300**
7	**$48,650**	**$65,678**	**$82,705**	**$97,300**
8	**$54,150**	**$73,103**	**$92,055**	**$108,300**
For each additional person, add	**$5500**			

It is a privilege and an honor to work with the St. Mary Parish School Board, faculty, and staff to ensure that the students and families of St. Mary Parish schools have immediate and convenient access to high quality, comprehensive healthcare services within the school system.

THE FOLLOWING IS A LIST OF MEDICATIONS THAT MAY BE ADMINISTERED BY THE PHYSICIAN ASSISTANT OR NURSE PRACTITIONER IN THE COURSE OF TREATING YOUR CHILD.

Medications for pain: • Ibuprofen • Naproxen • Acetaminophen • Theragesic Rub	**Medications for allergies:** • Benadryl • Loratadine
Medications used for colds & stuffy nose: • Advil Allergy/Congestion • Dayquil Severe Cold & Flu • Chloraseptic Throat Lozenges	**Medications to relieve coughing:** • Robitussin Cough Syrup • Robafen Cough Syrup • Cough Drops
Medications to cleanse wounds or eyes: • Normal Saline • Betadine Solution • Hydrogen Peroxide • Isopropyl Alcohol • Triple Antibiotic Ointment • Eye Wash Solution • Xylocaine 1% or 2% Subcutaneous	**Medications for stomach:** • Pepto Bismol • Gas-X • Emetrol • Loperamide Hydrochloride • Tums • Famotidine
Medications for Eyes/Ears/Mouth • Ear Wax Treatment Drops • Antipyrine and Benzocaine Otic Solution • Ketorolac Tromethamine Ophthalmic Solution • Artificial Tears • Oral Lidocaine • Orabase **Medications for Skin** • Triamcinolone Acetonide Cream • Clotrimazole Cream • Caladryl • Vaseline • Aloe Vera	**Other Medications:** • Azithromycin • Ceftriaxone • Depo-Medrol • Albuterol 0.083% (nebulizer) • Xopenex 0.63 mg (nebulizer) • Ammonia Inhalant • Normal Saline • Lactated Ringers • D5W Solution • Aspirin • Nitrostat • Epinephrine • Oral Glucose • Glucagon • Oxygen

****NOTE: GENERIC FORM MAY BE SUBSTITUTED**

I UNDERSTAND AND GRANT PERMISSION FOR THIS STUDENT TO RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER **EXCEPT** THOSE WHICH I HAVE WRITTEN HERE: _____

_____

Student Name and DOB

Parent/Legal Guardian Signature and Date

Flu Shots are available at the Teche Health School-Based Health Center.

Student's Name and DOB (print): _____ / DOB: _____

Parent's/Legal Guardian's Name (Please Print): _____

Warning	**Should not be given to be administered to anyone with known systemic hypersensitivity reactions to egg proteins (eggs or egg products), to chicken proteins, or to any component of the intended to receive influenza vaccine or who has had a life-threatening reaction to previous administration of any influenza vaccine individuals with bleeding disorders**
Adverse Reaction	**Local: pain, redness, and swelling** **Systemic: muscles aches, fatigue, headache, arthralgia, shivering and fever > 100.4F)**
Use in Pregnancy	**Medical Clearance Required**

Please check only 1 statement below:

☐ I am currently the parent/legal guardian of the student listed above, and **I give my consent** for this student to receive the Influenza vaccine at the Teche Health West St. Mary School-Based Health Center for the 2025-2026 school year.

You may contact the **SBHC at (337) 924-9646** to request a copy of the Influenza Vaccination Information Statement, which explains the risks & benefits of the vaccine. You may also find a copy at https://www.cdc.gov/vaccines/hcp/current-vis/downloads/flu.pdf. These VISs are also available in Spanish.

☐ I am currently the parent/legal guardian of the student listed above, and **I do not give my consent** for this student to receive the Influenza vaccine at the Teche Health School-Based Health Center.

Please have your child return this form to the Teche Health School Based Health Center located in Room 505. This form must be signed and dated.

Signature: _____ Date:_____

(Office Use Only) **Vaccination Date: _____**

Universal Vaccination *Consent and Screening Form* for Minors aged 6 months through 17 years

SECTION 1: INFORMATION ABOUT YOUR MINOR CHILD TO RECEIVE VACCINE (PLEASE PRINT)

MINOR'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S DATE OF BIRTH** (MM/DD/YEAR):	
MINOR'S RACE: ☐ White ☐ Black or African American ☐ Asian ☐Native American or Alaska Native ☐ Native Hawaiian or Pacific Islander			**ETHNICITY** ☐Hispanic ☐Non-Hispanic	**Is Minor a person with a disability?** ☐Yes ☐ No
PARENT/ LEGAL GUARDIAN'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S AGE**	**MINOR'S SEX at birth** ☐ Male ☐ Female
ADDRESS			**PARENT/GUARDIAN MOBILE NUMBER:** _____	
CITY	**STATE**	**ZIP**	**EMAIL:**	

The School-Based Health Center medical team will review **your child's record** to determine which shots are needed based on the child's age and CDC recommendations. Below, find information about required and recommended vaccinations.

School Required Immunizations:

REQUIRED VACCINATIONS FOR ENTRY INTO DAYCARE AND SCHOOLS

Daycares/Early Learning		Grade K-12 Schools			Post-Secondary Schools	
Vaccinations	Doses	Grades	Vaccinations	Doses	Vaccinations	Doses
Child must be up to date on vaccinations for their age (see recommendations listed above) according to a valid immunization record		Starting at Kindergarten[1] and all subsequent grades thereafter	DTaP[2]	5	MMR	2
			HepA	2	Tdap	1
			HepB	3	MenACWY	2 doses, or 1 dose if 1st dose administered on or after age 16
			IPV[3]	4		
			MMR	2		
			VAR	2		
		Starting at 6th grade and all subsequent grades thereafter	Tdap	1		
			MenACWY	1		
		Starting at 11th grade and all subsequent grades thereafter	MenACWY	Second Dose		

[1] Entry requirement exception for students who are 4 years of age when entering kindergarten at start of school year: To attend kindergarten in Louisiana, students must be 5 years old by September 30 each school year. Therefore, there are instances where a student is still 4 years old when entering kindergarten. In these instances, the 4-year-old student may be admitted into kindergarten so long as a parent/guardian presents a record indicating that the student is in progress of receiving the required vaccinations. In these instances, follow-up from school staff must be provided for compliance with the above requirements.
[2] Those students who received their 4th dose of DTaP at age 4 or older do not need a 5th dose on record.
[3] Those students who received their 3rd dose of IPV at age 4 or older do not need a 4th dose on record.
Note: Students may participate in school without the required immunizations listed above if a written statement of exemption is presented by a physician, the individual, or the individual's parent/guardian.

Pediatric/Adolescent Recommended Immunizations:

- Human Papillomavirus (HPV)
- Hepatitis A
- Influenza (Flu)
- Meningococcal B

Please visit http://www.immunize.org/vis/ to find the Vaccine Information Statement (VIS) for each vaccine, which explains risks and benefits of all vaccines.

SECTION 2: CONSENT. I understand the risks and benefits of the Immunization(s)/Vaccine(s) my child is eligible to receive. In providing my consent below, I agree that:

1. I will have provided to me the age-applicable ***Vaccine Information Statement Sheets*** for the Vaccine(s) the minor child named above is being authorized to receive
2. I have the legal authority to consent to have the minor child named above vaccinated.
3. I am not required to accompany the child named above to their vaccination appointments and that, by giving my consent below, the child may receive the Vaccine(s) whether or not I am present. **Parents/Guardians will be called prior to any child receiving a vaccine.**
4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs and/or administration of the Vaccine(s).
5. I understand that pursuant to state law, all immunizations will be entered into the Louisiana Immunization Network (LINKS) registry operated by the Louisiana Department of Health. More information about LINKS can be found at: https://ldh.la.gov/index.cfm/page/3660.

I GIVE CONSENT to **Teche Health (School-Based Health Center)** to vaccinate the minor child named above with the vaccines recommended **EXCEPT** for those I have listed here: _____

_____

Date: Month _____ Day _____ Year _____

Signature of the Parent/Legal Guardian (named above): _____

FOR CLINIC USE ONLY		
This child qualifies for vaccination through the VFC program because he/she (check only one box below); or ☐ is not qualified		
☐(a) is enrolled in Medicaid	☐ (b) does not have health insurance	☐ (c) is American Indian or Alaskan Native
I certify that the Important Vaccination Information Statement Sheets (VIS) for the vaccine(s) indicated below as administered were provided to the parent/guardian named above		
Clinic Name: **Teche Health** Site: _____ SBHC	Date Vaccinated: _____	Signature and Title of Vaccine Administrator: _____

Vaccine	Manufacturer	Lot#	Expiration Date	Route	Dose	Injection Site	EUA/VIS Date
HIB (Flu)							
HBV (Hepatitis B)							
HAV (Hepatitis A)							
Influenza (FLU)							
COVID-19							
HPV							
Meningitis ACWY							
Meningitis B							
OTHER:							
OTHER:							

Entered into LINKS (initial and date) _____ Notes/Comments: _____

COVID-19 Vaccine: Consent and Screening Form for minors age 6 months and through 17 years

SECTION 1: INFORMATION ABOUT MINOR CHILD TO RECEIVE VACCINE (PLEASE PRINT)

MINOR'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S DATE OF BIRTH** (MM/DD/YEAR):	
MINOR'S RACE ☐White ☐Black ☐ Asian ☐ Native American or Alaska Native ☐Native Hawaiian or Pacific Islander			**ETHNICITY** ☐Hispanic ☐Non-Hispanic	**Is Minor a person with a disability?** ☐Yes ☐No
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S AGE**	**MINOR'S SEX** ☐Male ☐Female
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER AND MOBILE NUMBER:**	
CITY	**STATE**	**ZIP**	**PARENT/GUARDIAN EMAIL:**	

Primary Insurance Plan Name:_____Policyholder Name _____

Member or Policy Number:_____Policyholder relationship to the patient:_____

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY: To help determine if your child should not get the COVID-19 vaccine.

	YES	NO	UNKNOWN
1. Is your child currently feeling sick or ill?			
2. Has your child ever received a dose of the COVID-19 vaccine? If yes, which vaccine? ☐ Pfizer-BioNTech ☐ Moderna 3. ☐ Another brand of vaccine: _____Date: _____ 4. How many doses has your child received? _____			
5. Does your child have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *(This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), or moderate or severe primary immunodeficiency.)*			
6. Has your child ever had a severe allergic reaction that required treatment with epinephrine or EpiPen® or that caused them to go to the hospital? *(This would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)* • A component of a COVID-19 vaccine? • A previous dose of COVID-19 vaccine?			

7. Has your child ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			

Check all that apply to your child:

- ☐ Has a history of myocarditis or pericarditis
- ☐ Has a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Has a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Has a history Guillain-Barre syndrome (GBS)
- ☐ Has a history of COVID-19 disease within the past 3 months?

SECTION 3: INFORMATION ON THE RISKS AND BENEFITS OF COVID-19 VACCINES

COVID-19 Vaccines may prevent the individual vaccinated from getting COVID-19. The U.S. Food and Drug Administration (FDA) has authorized the emergency use of certain COVID-19 Vaccines to prevent COVID-19 in individuals 6 months through 17 years under an Emergency Use Authorization (EUA), and has approved the Pfizer/BioNTech's *COMIRNATY (COVID-19 VACCINE, mRNA)* for ages 16 and above. For information about each vaccine and its side effects and possible allergic reactions, see this FDA website:

Multilingual COVID-19 Resources | FDA

SECTION 4: Type(s)/Brand(s) of COVID-19 Vaccine that I authorize the above-named minor child to receive:

[Parent/Guardian to circle one or more] *Pfizer-BioNTech/Comirnaty* *Moderna*

SECTION 5: CONSENT I have reviewed the information on risks and benefits of the COVID-19 Vaccine (Section 3, above) and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent and screening form.
2. I have read or had read to me the age-applicable *Fact Sheet for Recipients and Caregivers*, as posted at **Multilingual COVID-19 Resources | FDA**, for each of the types/brands of COVID-19 Vaccine(s) the minor child named above is being authorized to receive, as noted in Section 4 above.
3. I have the legal authority to consent to have the minor child named above vaccinated with the COVID-19 Vaccine.
4. I am not required to accompany the child named above to their vaccination appointments and that, by giving my consent below, the child may receive the COVID-19 Vaccine whether or not I am present.
5. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the COVID-19 Vaccine. The government is paying for the actual vaccine, and I will not be billed for that portion of the cost of my immunization.
6. I understand that pursuant to state law, all immunizations will be inputted to the Louisiana Immunization Network (LINKS) registry operated by the Louisiana Department of Health.

I GIVE CONSENT to _____ [INSERT VACCINATING ENTITY NAME] to vaccinate the minor child named at the top of this form with the COVID-19 Vaccine and have reviewed and agree to the information included in Section 4 of this form.

Date: month ____day _____year _____

Signature of the Parent/Legal Guardian (named above): _____

Manufacturer	Lot#	Expiration Date	Route	Dose	Injection Site	EUA Date	Current reported weight

Entered into LINKS (initial and date) _____ Notes/Comments: _____

rev. 08.04.2024

TECHE ACTION BOARD, INC. d/b/a TECHE HEALTH
SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

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 question about this notice, please contact Teche Action Board, Inc. at (337) 828-2550.

Who will follow this notice?

Teche Health @ Dulac	Teche Health @ Franklin	Teche Health @ Gramercy	Teche Health @ Houma
Teche Health @ Morgan City	Teche Health @ Pierre Part	Teche Health @ Reserve	Teche Health @ Thibodaux
Raintree Elementary School-Based Health Center		West St. Mary School-Based Health Center	

This notice describes our privacy practices. All the above sites and locations follow the terms of this notice. In addition, these sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

Our pledge regarding health information:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by HIPAA law to:

- make sure that health information that identifies you is kept private
- give you this notice of our legal duties and privacy practices with respect to health information about you
- follow the terms of the notice that is currently in effect

How we may use and disclose health information about you:

The following categories describe different ways that we may use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- Appointment reminders
- To allow oversight of the quality of the healthcare we provide
- To allow workers' compensation claims
- As required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety

<u>Your Rights Regarding Health Information About You</u>
You have the following rights regarding health information we maintain about you:

- ♦ Right to inspect and copy (retrieval and copying fees will be assessed)
- ♦ Right to an accounting of disclosure
- ♦ Right to request confidential communications
- ♦ Right to request an amendment
- ♦ Right to request restrictions
- ♦ Right to a paper copy of this notice

Changes to this notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. Any revised notices will be posted in our facility. In addition, each time you register for treatment or health care services we will offer you a copy of the current notice in effect.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Complaint Officer. All complaints submitted in writing may be mailed to Teche Health, Attn: Complaint Officer, 1115 Weber Street, Franklin, LA 70538 or you may call (337) 828-2550 ext. 2191. You will not be penalized for filing a complaint.

YOUR RIGHTS AS A PATIENT

1. You have a right to impartial access to treatment regardless of race, ethnic origin, age, sex, religion, handicap, or ability to pay (according to a sliding fee scale).
2. You have a right to a reasonable response to your request for treatment within the scope of the organization's mission, capacity, and regulations.
3. You have a right to considerate, respectful care at all times with consideration of your psycho-social, spiritual, and cultural values and beliefs.
4. You have a right to participate in the development and implementation of your plan of care.
5. You have a right to personal and informational privacy. You have a right to confidential treatment.
6. You have a right to access any information contained in your medical record.
7. You have a right to expect reasonable safety and security and to know how this organization will respond to disruptive behavior.
8. You have a right to expect an appropriate assessment and management of pain, information about pain and pain relief measures.
9. You have a right to be informed of any research or experimentation that could affect your care. You may then decide whether or not you want to participate in it.
10. You have a right to obtain complete and current information concerning your diagnosis, treatment, and any known prognosis.

YOUR RESPONSIBILITES AS A PATIENT

1. You are responsible for providing accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. You are responsible for reporting unexpected changes in your condition, including pain to the provider or nurse.
3. You are responsible for giving the clinic a copy of your advance directive, if one exists.
4. You are responsible for providing timely, accurate and complete information about your address, phone number, income, and insurance coverage to the clinic.
5. You are responsible for following the instructions and advice of your health care provider.
6. You are responsible for following the treatment plan with instructions recommended by your provider.
7. You are responsible for asking questions if you do not understand and clearly comprehend the contemplated course of action and what is expected of you.
8. You are responsible for notifying your doctor or nurse if you do not understand information about your care or treatment.
9. You are responsible for keeping all your scheduled appointments including appointments made by your provider for other tests and referral appointments for specialists.
10. You are responsible for canceling an appointment in advance if you are unable to keep it.