



# DENVER HEALTH

Level One Care For ALL

## *School-Based Health Center (SBHC)*

### ***COMPREHENSIVE ON-SITE HEALTH CARE FOR ALL DPS CHILDREN***

#### **Who can use a SBHC?**

Any DPS student is eligible to use a SBHC. Students are eligible regardless of insurance status or ability to pay. SBHC can serve as the primary point of care for a student or can work in conjunction with a student's primary care doctor.

#### **Why choose a SBHC?**

SBHCs offer convenient care that limits the amount of time students are out of class and parents/guardians have to be off work. In many cases, students are able to get same or next day appointments.

#### **What services may be offered?**

- Well Child Checks which meet the requirements of school, sports, camp, and employment physical exams. This may include routine lab tests, and immunizations.
- Prescriptions and medications
- Care for chronic conditions such as asthma and depression.
- Care for acute injury and illness.
- Reproductive health services including pregnancy testing and birth control evaluation, dispensing and management
- Testing and treatment for sexually transmitted infections
- Individual, group and family mental health counseling
- Dental screenings, routine cleanings, sealants and dental x-rays
- Parent and child health education

#### **Who provides services?**

- Nurse Practitioner, Physician Assistant or Physician
- Mental Health Therapist or Psychiatrist
- Substance Abuse Counselor
- Health Care Partner/Medical Assistant
- Health Educator
- Community Health Advisor/Outreach Worker
- Dental Hygienist

#### **Parent involvement?**

A parent or guardian must sign a consent form before their child may use any health center service. Once this is done, the child may use the health center at any time during the 18 month consented period.

Supporting family communication is a principle goal of the health center. Clinic staff encourages patients to discuss their health care with their parents. However, parents are not routinely notified when a patient uses the health center, except by patient request or when the staff becomes aware of serious health concerns.

#### **Confidentiality?**

Colorado state law allows some visits to the health center to be confidential as appropriate. Information is not shared without patient and/or parental permission. The only exception is a life-threatening situation.

#### **What does it cost?**

There is no charge to the patient or their family for services offered in the health center. Patients will not have to pay co-pays, deductibles or fees to be seen. Insurance may be billed but without cost to families.

#### **Insurance enrollment help?**

When registering for use of the clinic, families are asked to provide health insurance information or to apply for low-cost child health insurance options and discount programs. Insurance outreach and enrollment staff are available through the School-Based Health Center to assist families with the insurance application process.

*Denver Health respects the rights of our patients. It is our goal to demonstrate our support for patient rights through our interaction with patients and the way we involve them in care, treatment, and services. If you would like a printed copy of the Denver Health Rights and Responsibilities, please contact your school-based health center or call 303-602-8958.*

# DENVER HEALTH

## DENVER SCHOOL-BASED HEALTH CENTER SERVICES (DSBHC)

### PARENTAL CONSENT FOR TREATMENT

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

MRN: \_\_\_\_\_

I give consent for my student \_\_\_\_\_ Sex:  M  F DOB: \_\_\_\_\_  
First Name Middle Last Name

to receive necessary and/or advisable care provided by the DSBHC. I understand the following services may include:

physical exams • immunizations • routine lab tests • care for acute illness and injury • prescription medications • care for common adolescent physical concerns (weight, acne, menstrual problems) • care of certain chronic conditions such as asthma and seizure disorder • pregnancy testing • diagnosis and treatment of sexually transmitted infections • family planning, abstinence counseling the administration and management of birth control • prenatal/postpartum care services • drug and alcohol prevention and education • mental health services including individual, family and group therapy • follow-up care as needed

Dental services available in the DSBHC include screenings, routine cleanings, x-rays and sealants. Any diagnosis or assessment completed solely by the registered dental hygienist is for determining necessary dental hygiene services only. It is recommended by the American Dental Association that a dentist perform a comprehensive dental examination twice each year.

**Release of Information:** I understand my student's medical record is protected health information and all requests for my student's medical records require a signed consent by student's parent/guardian. DSBHC may disclose health information for payment, treatment, and health care operations as described in Denver Health's Notice of Privacy Practices. As allowed by Colorado law, my student may request confidential visits meaning all health information from the visit will remain confidential. Access to my student's medical records from a confidential visit will remain confidential and release of medical records to parent/guardian or any interested party requires a signed release of information from the student. I give my permission to DSBHC staff to examine and/or copy my student's school records including immunization records, attendance, and any records that are necessary for DSBHC staff to provide the care and/or treatment for my student.

**DSBHC Fees, billing, authorization, and consent:** On behalf of my student, I authorize Denver Health and Hospital Authority ("DHHA") any and all benefits that either my student or I may be entitled to receive for healthcare services provided by DSBHC from any payer of benefits including any person, entity, insurance company, health benefit plan, or governmental healthcare program. DHHA has authorization to file claims with, and collect payments from, the payer of benefits, and the payer of benefits to make payment directly to, and solely to the order of, DHHA. I agree to assist DHHA in submitting and collecting claims from the payer of benefits in any reasonable manner requested. I authorized DHHA and its care providers to disclose to the payer of benefits any information from my student's medical and billing records necessary to obtain payment. I understand that once information is released DHHA will be unable to control its confidentiality.

Does your student have major health problems?  YES  NO Please explain: \_\_\_\_\_

Is your student allergic to any Medications?  YES  NO If YES list medications: \_\_\_\_\_

Student's School: \_\_\_\_\_ Grade: \_\_\_\_\_ DPS Lunch ID #: \_\_\_\_\_

Student's Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Country of Student's Birth: \_\_\_\_\_

Student's Race/Ethnicity circle all that apply (optional):

Hispanic/Latino   American Indian   White   Black/African American   Asian   Other: \_\_\_\_\_

Mother/Guardian (Name): \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Father/Guardian (Name): \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Emergency Contact (Different than above): \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Name of Student's Medical Clinic/Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Student's MRN: \_\_\_\_\_

Insurance Information - my student has health insurance coverage:  YES  NO

Medicaid ID #: \_\_\_\_\_  CHP+ ID #: \_\_\_\_\_  CICIP/DFAP

Name of Private Insurance: \_\_\_\_\_ Policy/Member #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_

**CONSENT:** I have received the DSBHC packet that explains the services provided by DSBHC. I understand this consent will remain valid for 18 months from the date of my signature. I understand I am responsible to notify DSBHC with any changes in guardianship and/or insurance. I have the right to revoke this consent for my student at any time with written documentation to DSBHC stating this.

**Signature Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Parent/Guardian:** \_\_\_\_\_



**DENVER HEALTH  
DENVER SCHOOL-BASED HEALTH CENTER  
IMMUNIZATION CONSENT FORM**

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YY

**Student's School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Sex:**  Male  Female

**Parent or Legal Guardian name:** \_\_\_\_\_

Immunizations are offered at Denver Health School Based Health Centers to protect your student against many serious diseases. Prior to immunizing, Denver Health checks multiple databases and records to confirm that students are only given immunizations they have not received.

Vaccines are designed to prevent life threatening, debilitating illnesses, and cancer. These include:

Disease	Vaccine	Disease	Vaccine	Disease	Vaccine
Tetanus	Tdap/Td/Dtap	Polio	IPV	<b>For children under 5 years old</b>	
Diphtheria		Hepatitis A	Hep A	Severe diarrhea	Rotavirus
Pertussis		Hepatitis B	Hep B	Bacterial Disease	HIB
Measles	MMR	Meningococcal Meningitis	MCV4	Pneumonia	PCV13
Mumps		Human Papillomavirus	HPV9		
Rubella		Influenza	LAIV or TIV		

*NOTE: Each of these immunizations is recommended by the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP).*

- List the name(s) of the immunization(s) you do **NOT** want your student to receive here: \_\_\_\_\_
- Has your student ever had a serious reaction to a vaccine?
  - Yes If so, what was the reaction and to what vaccine? \_\_\_\_\_
  - No

I give my permission for my student to receive immunizations at the School-Based Health Center, except for the specific immunization(s) listed above. I request that those immunizations be given to the student named above, for whom I am authorized to make this request. I further agree to have information shared with my student's primary care provider. I also agree to have my student's immunization record stored in my student's school health record, the Denver Health electronic record (eHR), and the Colorado Immunization Information System (CIIS). Vaccine Information Statements (VIS) about the disease prevented and the vaccines given have been offered and my questions answered.

<b>I authorize Denver Health School-Based Health Center to immunize my student.</b>		
_____ Parent or Guardian Signature	_____ Relationship to Student	____/____/____ Date (MM/DD/YY)

I do NOT authorize Denver Health School-Based Health Center to immunize my student.

_____ Parent or Guardian Signature	_____ Relationship to Student	____/____/____ Date (MM/DD/YY)
---------------------------------------	----------------------------------	-----------------------------------

# DENVER HEALTH MEDICAL CENTER PARENT/GUARDIAN QUESTIONNAIRE CHILD/TEEN/FAMILY HISTORY

## Child/Teen Health History

- Does your child take **medication**?  No  Yes If yes, what? \_\_\_\_\_
- Has your child had **serious medical** or **mental health problems**?  No  Yes  
If yes, what? \_\_\_\_\_
- Has your child been **hospitalized overnight** or had **surgery** or any **serious injuries**?  No  Yes  
If yes, what? \_\_\_\_\_
- Does or did your child have any of these problems **now** or in the **past**?
 

<input type="checkbox"/> Allergies to food, medicine, or anything else?.....if yes, what? _____	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Birth Problems	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Blood Clots/Stroke	<input type="checkbox"/> Mental Illness/ Depression
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Seizures
<input type="checkbox"/> Development/Learning Delays	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis / TB / Positive TB Test
<input type="checkbox"/> Drug / Alcohol Abuse	<input type="checkbox"/> Other _____

## Family History

Does anyone in your family (parents, siblings, grandparents, aunts/uncles) have any of these problems, **now** or in the **past**?

- Asthma ..... if yes, who? \_\_\_\_\_
- Blood Clots/Stroke..... if yes, who? \_\_\_\_\_
- Cancer..... if yes, who? \_\_\_\_\_
- Diabetes ..... if yes, who? \_\_\_\_\_
- Drug/Alcohol Abuse..... if yes, who? \_\_\_\_\_
- Heart Disease..... if yes, who? \_\_\_\_\_
- High Blood Pressure ..... if yes, who? \_\_\_\_\_
- High Cholesterol..... if yes, who? \_\_\_\_\_
- Mental Illness/Depression ..... if yes, who? \_\_\_\_\_
- Sickle Cell Anemia ..... if yes, who? \_\_\_\_\_
- Tuberculosis / TB / Positive TB Test..... if yes, who? \_\_\_\_\_



Parent/Guardian Signature \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_

Staff Signature/Title \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_ Time (00:00) \_\_\_\_\_ (Pager & Provider #) \_\_\_\_\_



Name, MR#, Pat#, DOB

# DENVER HEALTH AND HOSPITAL AUTHORITY NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL 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, contact a Patient Representative at 303.602.2915 or the Privacy Officer by phone at 303.436.8886; by fax at 303.602.7024; or by mail at 777 Bannock Street, MC 7776, Denver, CO 80204. To learn more about Denver Health, please see [www.DenverHealth.org](http://www.DenverHealth.org).

Medical information about you and your health is private. We strive to protect your health records when you are in the hospital and when you are being seen in the clinics. We will use your records to care for you, to bill for care, to run the hospital, and to comply with the law. This Privacy Notice applies at all Denver Health and Hospital Authority (Denver Health) inpatient, outpatient, community clinic, and emergency services sites except for parts of the Rocky Mountain Poison and Drug Center and Denver Public Health, which do not have to follow this Notice.

This Notice tells you about the ways Denver Health may use or give out information from your private health records. It also explains your rights and our responsibilities.

### Who Follows The Terms of This Notice

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical information to do their jobs

### Acknowledgement of Receipt

I understand that, as allowed and required by law, Denver Health staff will use and give out my health records, without my consent or authorization, for:

- **Treatment:** Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- **Payment:** Denver Health will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- **Healthcare Operations:** Denver Health will use my health records to run the hospital and clinics and to make sure patients receive quality care.

Otherwise, Denver Health will follow the restrictions in this Notice of Privacy Practices.

I acknowledge that I have received a copy of Denver Health's Notice of Privacy Practices.

\_\_\_\_\_  
Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative's Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### **Get an Electronic or Paper Copy of Your Medical Record.**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. To see or get a copy of your records, please talk to the staff where you get your care or the Medical Records Department at 303.602.8001. You may be asked to fill out a form. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

In some cases, we may deny your request to read or get a copy of your records. We will give you the reason for the denial. If your request is denied, you can ask that the denial be reviewed. A care provider chosen by Denver Health will review your request. This person will not have taken care of you or have been involved in the first review. We will follow what they decide.

### **Ask Us to Correct Your Medical Record.**

You can ask us to correct health information about you that you think is incorrect or complete. To ask for a correction, please talk to your care provider, staff where you receive care, or the Medical Records Department at 303.602.8001. You may be asked to fill out a form and to give a reason for your request. We may say "no" to your request, but we will tell you why in writing within 60 days.

### **Ask for Confidential Communications.**

We may contact you to remind you about an appointment, to tell you your test results, to give you information about services that may be of help or interest to you, or for other reasons related to your health. You can ask that we contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

To ask for specific confidentiality, talk to your care provider or staff where you receive care. We will not ask you the reason for your request. You must tell us how or where you want to be contacted.

### **Ask Us to Limit What We Use or Share.**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

To ask us to limit how we use or give out your health information, talk to your care provider or staff where you receive care, contact the Medical Records Department at 303.602.8001 or contact the Privacy Officer at 303.436.8886. You may be asked to fill out a form.

### **Get a List of Those with Whom We Have Shared Your Information.**

You can ask for a list (accounting) of the times we have shared your health information for six years before the date you ask, who we shared it with, and why. We will include all of the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

To ask for this list, please call the Medical Records Department at 303.602.8001. You will be asked to fill out a form. You can get one list free a year, but we will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a Copy of this Privacy Notice.**

You can ask for a paper copy of this Notice at any time, even if you already have one. We will provide you with a paper copy promptly, and it is always available on our website at [www.denverhealth.org](http://www.denverhealth.org).

### **Choose Someone to Act for You.**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a Complaint if you Feel Your Rights are Violated.**

You can complain if you feel we have violated your rights. All complaints must be given to us in writing. Mail to: Privacy Officer, 777 Bannock Street, MC 7776, Denver, CO 80204. Fax to: 303-602-7024. You can also make a complaint to the Secretary of the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint and your care will not be affected.

## **YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation, such as the Red Cross, so that your family can be called or told about your health status.
- Include your information in a hospital directory so your family and friends who ask for you by name can call or visit you and so that you can get mail and flowers. If you do not object, we will include your name, your location, and your general condition. Also, you can tell us your religion if you want, and members of the clergy who ask to visit patients of your religion will be given your name.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- Most sharing of alcohol and drug abuse treatment information maintained by Denver Health's federally assisted substance abuse treatment programs

### **Fundraising.**

We may use your information to contact you in an effort to raise money for Denver Health. We may share this information with our affiliated Denver Health Foundation to work on our behalf. If you do not want to receive communications about fundraising (to opt out), or you wish to opt back in, call the Foundation at 303-602-2970, or send an e-mail to: [dhfoundation@dhha.org](mailto:dhfoundation@dhha.org).

**Colorado Regional Health Information Organization (CORHIO).** CORHIO is a nonprofit organization of hospitals and doctors whose mission is to improve health care by allowing participating hospitals and doctors to exchange medical information electronically between them. This allows all of your care providers at different organizations to view your health information so that they can make better decisions about your care. If you do not want Denver Health to share your information with other participating hospitals and doctors through CORHIO, you can "opt out" by writing to the Denver Health CORHIO Point of Contact, 301 W 6th Avenue, MC 0296, Denver, CO 80204.

## **HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION**

We typically use or share your health information in the following ways:

### **Help Manage the Health Care Treatment You Receive.**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

### **Bill for Your Health Services.**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **Run Our Organization.**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services and to develop better services for you.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help With Public Health and Safety Issues.**

We can share your health information for certain situations such as:

- Preventing disease
- To report births and deaths
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence and victims of crime
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting crimes in the hospital or clinics



### **Do Research.**

We can use or share your information for health research.

### **Comply With The Law.**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to Organ And Tissue Donation Requests**

We can share information about you with organ procurement organizations such as Donor Alliance.

### **Work with A Medical Examiner Or Funeral Director.**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address Workers' Compensation, Law Enforcement, and Other Government Requests.**

We can use or share health information about you:

- For workers' compensation claims
- To your employer for:
  - a job related injury or illness;
  - workplace-related medical review; or
  - if your employer needs the record to follow the law.
- For law enforcement purposes or with a law enforcement official
- With the jail, prison, or police if you are an inmate or are in custody so they can take care of you and protect the health and safety of you, other inmates, and staff.
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond To Lawsuits And Legal Actions.**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Privacy Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. Your request will be processed as soon as possible, but we may have already used or given out your records based on your prior authorization.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice.**

We can change the terms of this Privacy Notice, and the changes will apply to all information we have about you. The new Privacy Notice will be available upon request, in all hospital and outpatient locations, and on our web site.