Return this form to the Wellness Center or University Academy's Central Office. Please do not give this form to your child's teacher or other school staff.

Student Registration Information

Before your student can receive the services offered by the Wellness Center, a parent/legal guardian registration packet must be signed and on file in the Center.

Please register your child by signing the registration, consent, and HIPPA forms, and returning them to the Wellness Center.

Our relationship with the patients and their parents is very important. We strongly encourage and welcome the involvement of parents and guardians.

For care after hours, please call your regular doctor or clinic. The Children's Mercy Hospital offers 24 hours a day, seven days a week a nurse triage line for their patients at 816-234-3188.

For life threatening emergencies, please call 911 or go to the closest emergency room.

All care received outside the Wellness Center is the financial responsibility of the student and their family.

Participation in the Wellness Center is voluntary, and you may withdraw permission at any time in writing.

Please make sure that your contact information is current so we can obtain consent when needed.

University Academy

School Based Wellness Center

Grades K-5

Operated By

Children's Mercy HOSPITALS & CLINICS
www.childrens-mercy.org

With additional financial support from Baptist Trinity-Lutheran Legacy Foundation, Arvin Gottlieb Charitable Foundation, and other generous contributions

Dear Parent/Guardian:

The Wellness Center provides **no cost** health services for all registered students. This is a separate service from the school nurse and requires completion of this form. The University Academy Wellness Center is staffed by Children's Mercy Hospital (CMH) employees.

As a student, University Academy provides the following services for all students registered in the clinic:

- Sports physicals
- Minor illness & injury
- Mental health evaluation & referral
- Chronic disease management such as for asthma

An annual consent form must be on file in the Wellness Center. The Center will attempt to notify the parents or guardians at all visits. Please do not hesitate to contact the Center if you have any questions.

You will be contacted for your consent for us to examine and treat your child when your consent is required.

The Wellness Center will continue to obtain insurance information for clinic report purposes only. Insurance will not be billed. Families without insurance will be contacted for available resources.

All services are provided in a confidential manner, and the records for the Wellness Center are maintained separately from the student's school records. The records of care received in the Center by CMH staff are the property of CMH. Requests for these records must be made through the medical records office at the Hospital.

It is important to have a medical home. Wellness Center personnel are happy to work with your doctor's office to provide the best care. If you are looking for a regular doctor, please talk to the Center's personnel.

If you have any questions about the services provided by the Wellness Center, please call 816-412-5978.

University Academy Wellness Center

Grade K-5 Registration

I give permission for:

_____
(Please Print Student's Name)

Date of Birth _____

Gender (circle) Male Female

Parent/Guardian home phone #_____

Parent/Guardian work phone #_____

Parent/Guardian cell phone #_____

Insurance _____

Insurance ID # _____

Parent/Guardian responsible for insurance_____

I understand the purpose of the Center and agree for my child to receive all the services, except for (please be specific):

_____

_____

My child's regular doctor/clinic is:

_____

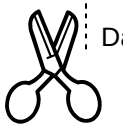
Parent/Guardian Signature

_____

Printed Name _____

Relationship _____

Date _____



Children's Mercy

Informed Consent for Medical or Dental Treatment

(Front)

8071-051 MR 01/17 (Translated 01/17)

I hereby authorize, for the patient named below, examination and treatment by members of the medical staff of The Children's Mercy Hospital (CMH), residents, and any assistants or designees deemed necessary by the physician, practitioner or dentist. I realize that among those who provide patient care at CMH are medical, dental, nursing, allied professionals, and other health care personnel in training who may be participating in patient care as a part of their education. I also understand that some physicians providing my services are not agents or employees of the facility, but are independent physicians who have been granted the privilege of using its facilities for the care and treatment of patients. I hereby authorize the collection of medication history from regional and national databases for the purpose of providing patient care. I am aware that the practice of medicine, dentistry, and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination at CMH. I hereby authorize the pathologist or other designated personnel to dispose of, or use for internal or external quality control and test validation, in accordance with established policy, any tissue or specimens resulting from a procedure.

PHOTOGRAPHS AND VIDEOTAPING

I authorize the closed circuit monitoring, photographing, and videotaping of this patient, and the confidential use of the resulting images and data, for medical and teaching purposes.

AUDIOVISUAL ENCOUNTERS

I authorize the use of secure interactive video communications and the secure electronic transmission of information between this patient and CMH staff. An audiovisual encounter is the exchange of information between CMH staff caring for a CMH inpatient or outpatient while onsite at CMH and a family member or caregiver who is authorized to receive such information by audiovisual means in another location.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby assign benefits and authorize payment, directly to CMH and the practitioners providing care, any and all benefits from any third party medical insurance coverage, including but not limited to Medicare and Medicaid benefits, for services provided. I certify that the information I have given to CMH is correct and complete. Furthermore, I authorize the release of any information needed to determine my benefits or secure payments. I understand that CMH bills as either an outpatient or inpatient hospital. I understand that Children's Mercy Hospitals and Clinics will bill all outpatient services as specialty outpatient hospital services. I understand that I am financially responsible for any and all charges incurred for services that are provided and not covered by insurance and I agree to promptly pay CMH and the practitioners providing care. In the event of non-payment, the Hospital reserves the right to make inquiries of outside sources, such as credit agencies, to obtain information with regard to household size, income, and credit scores for the Responsible Party.

Primary Care Physician: _____

Patient's Name: _____

Date of Birth (month/day/year): _____ Phone Number: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Patient or Legal Guardian: _____

Printed name of Patient or Legal Guardian: _____

Relationship to Patient: _____ Today's Date (month/day/year): _____ Time: _____

TELEPHONE AND INTERPRETER CONSENT: **STAFF USE ONLY**

I read the above statement to _____, reached at (___)___-____ on ____/____/____ at _____ hours; he/she stated understanding and approval.

_____ ____/____/____

Signature of 1st Witness — Printed Name — Date

_____ ____/____/____

Signature of 2nd Witness — Printed Name — Date

_____ ____/____/____

Interpreter's Signature — Printed Name — Date

Children's Mercy

Acknowledgement of Receipt of Information

(Front)

8071-174 MR 12/17 (Translated 12/17)

I. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of the care and services I receive at The Children's Mercy Hospital and Clinics (CMH), CMH creates a record of my visit which includes my health information. I acknowledge that I have been offered or given a copy of the CMH *Notice of Privacy Practices* (Notice) which describes how my health information may be used and disclosed by CMH, and my rights with respect to such information.

II. ACKNOWLEDGMENT OF RECEIPT OF PATIENT RIGHTS, RESPONSIBILITIES AND RULES

I acknowledge that I have been offered or given a copy of the CMH *Patient Rights, Responsibilities, and Rules.*

III. PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGES

- I acknowledge that I have been offered or given a copy of the CMH *Electronic Health Information Exchange Rights.*
- I understand that CMH participates in Health Information Exchanges and that I have the right to opt out of the exchange.
- CMH will include my information in the Health Information Exchanges unless I specifically opt out. To opt out, I must contact the CMH Patient Access Department at (816) 234-3567 or tell a registration staff member.

IV. CONSENT FOR CORRESPONDENCE BY TELECOMMUNICATIONS

- I consent to allow CMH and its authorized affiliates, service providers and agents to contact me at the telephone number I provided to CMH (or any telephone number I provide in the future) using an auto-dialer, text message, facsimile message, artificial voice or pre-recorded message, regardless of whether the telephone number is a mobile number or if I incur charges as a result. CMH is authorized to contact me about services provided to me in the past or future. I also acknowledge that providing a phone number is not a condition of receiving services from CMH.
- If I later want to revoke this consent, I agree that I will only revoke consent by putting this revocation in writing and mailing it to the following address: The Children's Mercy Hospital, Attn: Patient Access Department, 2401 Gillham Road, Kansas City, MO 64108.

By signing below, I acknowledge that I have read and understand this form. If this document is being signed on behalf of a minor by a legal guardian, the signatory understands that the term "I" and "my" in this document refers to such minor and his/her rights.

Signature of Patient or Legal Guardian: _____

Printed Name: _____

Relationship to Patient: _____ Today's Date: _____ Time: _____

STAFF USE ONLY. If interpreted:

Interpreter's Signature: _____ Today's Date: _____ Time: _____

Printed Name: _____

Children's Mercy HOSPITALS & CLINICS

Authorization to Exchange Medical Information (Front)

8071-061 MR 10/06

Patient Name: _____ Medical Record Number: _____

Street Address: _____

City, State, Zip Code: _____

Regarding the patient named above, I hereby authorize _____ Clinic of The Children's Mercy Hospital to exchange with the individual or facility named below the information specified in this authorization form.

Name of Individual (if applicable): _____

Facility: University Academy

Address: 6801 Holmes Rd

City, State, Zip Code: Kansas City, MO. 64131

Telephone: (816) 412 - 5978 Fax: (816) 302 - 9635

INFORMATION TO BE EXCHANGED (SPECIFY): Sports Physical, immunizations, Asthma Action Plans

SEE MEDICAL RECORDS TO RELEASE OR RECEIVE COMPLETE HEALTH RECORD

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Medical Records department of The Children's Mercy Hospital or to the individual or organization named above. Unless this authorization is revoked, it will expire one (1) year from the date of signature.

I do not need to sign a specific authorization to disclose information for treatment, payment, or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have the information copied to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Medical Records department of The Children's Mercy Hospital at (816) 234-3455.

_____ _____ / _____ / _____

Signature of Patient/Parent/Legal Guardian Printed Name/Relationship Date

_____

Street Address

_____ ( ) _____ - _____

City State Zip Code Phone Number

MEDICAL RECORDS TO FILE – NO OTHER ACTION REQUIRED