YMCA School Based
Consent for Treatment

Mason Health School Based Health Clinic (MHSBHC) is located at **South Sound YMCA**. A signed consent is required from a parent or legal guardian before providing health care services, except in situations where federal and/or state laws allow youth to access and consent to treatment without parent/guardian consent.

_______ (Initial) I request and authorize

_______ (initial) I do **NOT** request or authorize

Print Student/Youth Name: _______________________________ **Date of Birth:** ______________
First Name, Middle Initial, Last Name

to receive health care services available from and deemed necessary or advisable by Mason Health School Based Health Clinic **(MHSBHC)** or Shelton School District Nursing Staff.

Health care services may Include, but are not limited to routine medical exams, sports physicals, well-child or well-teen care, evaluation and treatment of acute illness and injuries, immunizations, photographs for medical charts, **MHSBHC** staff encourages family involvement in the care they provide to youth. However, if I am unable to be present, authorization is given for above youth to receive services in my absence. Consent is also given for referral of care and, if necessary, emergency transportation to other healthcare providers or agencies deemed necessary by the **MHSBHC** staff. This consent does not allow services to be given without youth consent unless youth is unable to consent.

I understand I will be required to sign additional consent for mental health disclosures and **prior to** immunization vaccination administration and/or procedures.

I understand it Is my responsibility to report any changes in the youth's medical, behavioral health, or dental history to the clinic. Unless changes are noted by me, the provider can assume that there have been no changes in the youth's medical history.

Minors may self-authorize consent to treatment in the following statutory exceptions:

1. Sexually transmitted disease testing/treatment (including HIV) – (14 and older) RCW 70.24.110
2. Birth control services–at any age. RCW 9.02.100(1)
3. Abortion services–at any age. RCW 9.02.100(2); State v Koome, 84 Wn.2d 901 (1975)
4. Prenatal care services–at any age. State v Koome, 84 Wn.2d 901 (1975)
5. Outpatient mental health treatment–age 13. RCW 71.34.530
6. Inpatient mental health– age 13. RCW 71.34.510
7. Substance Use Disorder (SUD) age 13. RCW 70.96A.230

Patient Label

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT: We keep a record of the healthcare services we provide you. You may ask to see and copy that record from Health Information Management (HIM). You may ask to correct that record by contacting HIM. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Mason Health Privacy Officer at 360-427-9585 or by emailing privacy@masongeneral.com.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By signing this document, I acknowledge receipt of the Notice of Privacy Practices.

In accordance with federal and/or state laws, when consent is provided for care, health information is kept confidential except in the following circumstances:

- The youth permits release of information through a signed authorization, when appropriate.
- The youth exhibits a risk of imminent harm to self or others.
- The youth has a life-threatening health problem and Is under 18 years old.
- There is reason to suspect abuse or neglect.
- Certain communicable diseases must be reported to public health authorities,
- Other disclosures as required by law.

_______ (Initial) I authorize my child's school to release basic Family Educational Rights & Privacy Act (FERPA) demographic information (name, date of birth, address, phone number, insurance, medications, and allergies) to **MHSBHC** staff to allow for care coordination. An authorization for records release with a parent/guardian signature is required if records need to be released to my child's school.

Consent is authorized for services provided by **MHSBHC** during the length of time the youth is enrolled in a school with the Shelton School District. Withdrawal of this consent can be done at any time by writing to the **MHSBHC** and turning it in to Mason Clinic.

FINANCIAL ASSISTANCE: No one requiring necessary urgent or emergent treatment will be turned away from Mason Health because of the inability to pay or the lack of medical insurance. Mason Health provides FINANCIAL ASSISTANCE for urgent and emergent care. Charges for persons meeting medical indigence criteria may be waived or reduced. You may apply for Financial Assistance for treatment you receive at Mason Health. Financial Assistance is generally secondary to ALL other financial resources available to the patient. Accounts in collection in legal status do not qualify for consideration for Financial Assistance. Please ask for our Financial Assistance Policy for guidelines.

OTHER FINANCIAL POLICIES: Mason Health offer a variety of discounts for payment in full:

For services rendered at the hospital a 25% discount is available only if we do not bill any insurance and if the balance on the account is paid in full within 30 days of date of service.

For services rendered at any of our clinics a 10% discount is available only if we do not bill any insurance and if the balance on the account is paid in full within 30 days of date of service.

Tax Adjustment – this is available to homeowners that own their home in Mason County (appropriate tax documents must be provided). Amount Allowed: Up to total Mason County hospital district assessed taxes for Mason County properties for the current year to cover out-of-pocket hospital expenses. This adjustment is offered one-time per calendar year with a maximum of $250.00 per year.

FINANCIAL AGREEMENT/ASSESSMENT OF BENEFITS: I hereby assign to Mason Health, to the hospital-based emergency room physicians, and other third party contractors, any benefits I may have or am entitled to, arising out of any applicable insurance company, third party payor, worker's compensation carrier, self-insured employer group or other person or entity (or their authorized representatives) which may be financially responsible for my healthcare services. I hereby authorize payment directly to Mason Health and such hospital-based emergency room physicians, to be applied against my bill. I understand that other providers of care may bill me separately for their services incurred during my hospital care. These include but are not limited to my admitting and attending physicians, consultants, radiologists, lab, pathologists, and anesthesiologists.

I agree to pay all fees and charges shown on my statements/billing forms, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing in advance of service.

A copy of this assignment is as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I agree that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon.

I understand that it is my responsibility, and not that of Mason Health, to obtain proper insurance or other payer authorization for medical examination or other treatment, and that I am responsible for payment for all services rendered, whether or not such services might have been covered by insurance or other source, had proper authorization been obtained. I understand that if I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, or if my exam has not been properly authorized by my Primary Care Provider and/or insurance company prior to my appointment date, I am liable for all services rendered.

In the event collection efforts, including but not limited to legal action, should become necessary to collect any unpaid balance due for medical services rendered to me or the below named person, I agree to pay the reasonable fees under RCW 19.16.500 and the costs of collections, including but not limited to attorney's fees, court costs and additional legal fees associated with the recovery of this debt. I agree that the venue for any legal actions shall be Mason County, Washington. Interest may be charged at the rate of 9% or the maximum rate authorized by law, whichever is less, per annum for unpaid balances over 30 days old. All accounts are due and payable in full within thirty (30) days from the statement date. I understand and agree that Mason Health, its affiliates, agents, or designees may contact me using pre-recorded/artificial voice messages and/or automatic dialing services at any telephone number I provide to Mason Health.

Third party liability insurance cases are the patient's responsibility. Mason Health does not wait for settlement. The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient's agent to execute the above and accept all items and conditions. A copy of this charge agreement is to be given to the person signing.

______________________________ ______________________
Signature of Student/Youth (required for 13 and older) Date

______________________________ ______________________________ ______________
Signature of Parent/Legal Guardian Print Name Date

______________________________ ______________________________
Relationship to Student Phone Number

Patient Label

Mason Clinic

☐ Eye Care
☐ General Surgery
☐ Imaging
☐ Laboratory
☐ Orthopedics
☐ Pediatrics
☐ Podiatry
☐ Primary Care
☐ Walk-In
☐ Women's Health
☐ Family Health
☐ Olympic Physicians
☐ Hoodsport Primary Care

DATE: ____________________________

Legal Name (Last, First MI): ____ **Other Name:** _______________

Gender: ☐ *Female* ☐ *Male* **SSN:** ___________________________ **Date of Birth:** _____________

Race: ☐ *Caucasian/White* ☐ *Black* ☐ *Unknown* ☐ *Eskimo* ☐ *Hispanic/Latino* ☐ *American Indian* ☐ *Asian* ☐ *Pacific Islander/Native Hawaiian* ☐ *Other:* ____________ **Ethnicity:** ☐ *Hispanic* ☐ *Non-Hispanic*

Address: __________________________________ **City:** _______________ **State:** ____ **Zip Code:** __________

Residence: ________________________________ **City:** _______________ **State:** ____ **Zip Code:** __________

Home Phone: ____________________ **Cell:** ________________ **May we leave a detailed message: Y/N**

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Other:* _______________

Language: ___________________ **Religion:** _________________ **Email:** _____________________

Employment Status: ☐ *Full Time* ☐ *Part Time* ☐ *Self-employed* ☐ *Retired-Date:* _______________ ☐ *Student* ☐ *Child* ☐ *Unemployed*

Employer: ______________________________________ **Employer Address:** ________________________

Occupation: ________________________________ **Work Number:** _______________________

Primary Care Provider: ________________________________

Guarantor Name: ____________________________________ ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other* ___________

Primary Insurance: ______________________________ **Insured:** ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other* _________

ID #: ____________________________ **Group #:** ______________

Policy Holder: ____ **DOB:** ___________________

☐ *Full Time* ☐ *Part Time* ☐ *Self-employed* ☐ *Retired* **Policy Holders Employer:** ____________________________

Secondary Insurance: ____________________________ **Insured:** ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other* _________

ID #: ____________________________ **Group #:** ______________

Policy Holder: ____ **DOB:** ___________________

☐ *Full Time* ☐ *Part Time* ☐ *Self-employed* ☐ *Retired* **Policy Holders Employer:** ____________________________

Emergency Contact: ________________________ **Patient Relation to EC:** __________ **Phone:** __________

Next of Kin: _________________________ **Patient Relation to NOK:** ___________ **Phone:** _____________

____ _________________________________ ___________

Signature (Patient / Parent / Legal Representative) **Relationship to Patient** **Date/Time**