Dear Parent/Guardian:

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

I give permission for:

[Date]

[Parent/Guardian Signature]

My child's regular doctor, please link to the regular doctor, please link to the provider for the best care. If you are looking for a provider, use your doctor's office to provide work with your doctor's office to provide.

Wellness Center personnel are happy to work with your doctor's office to provide.

It is important to have a medical home.

Medical records office at the hospital.

Records must be made through the center. If the center is closed, the center will be closed.

The records of care received in the records. The records of care received in the records. The students the students the students the students the students.

All services are provided in a confidential manner, and the record for confidentiality.

Resources will be available for all services.

Families with insurance will call the office for availability.

If you are uninsured, please call the wellness center for availability.

The Wellness Center will continue to offer services as long as a student is registered in the clinic.

As a student, University Academy employees.

Children's Mercy Hospital (CMH) is staffed by University Academy Wellness Center is staffed by University Academy staff.

This is a separate service for all students. This is a separate service for all students.

The Wellness Center provides:

- Annual consent form
- Substance abuse evaluation
- Substance abuse treatment
- Sexual transmitted disease
- Birth control

And for adolescents:

- Clinical disease management
- Referral
- Mental health evaluation
- Minor illness or injury
- Sports physical

In addition, students registered in the clinic.

The Wellness Center provides:

- Annual consent form
- Substance abuse evaluation
- Substance abuse treatment
- Sexual transmitted disease

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

I give permission for:

[Date]

[Parent/Guardian Signature]

My child's regular doctor, please link to the regular doctor, please link to the provider for the best care. If you are looking for a provider, use your doctor's office to provide work with your doctor's office to provide.

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- Annual consent form
- Substance abuse evaluation
- Substance abuse treatment
- Sexual transmitted disease

And for adolescents:

- Clinical disease management
- Referral
- Mental health evaluation
- Minor illness or injury
- Sports physical

In addition, students registered in the clinic.

The Wellness Center provides:

- Annual consent form
- Substance abuse evaluation
- Substance abuse treatment
- Sexual transmitted disease

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

I give permission for:
Grades 6-12
Wellness Center
School Based

University Academy

Staff, your child's teacher
not give this form to
Office. Please do
Academy's Central
the Wellness Center
Return this form to
Grades K-5
Wellness Center
School Based

University Academy

www.childrensmercy.org

The Children’s Mercy Hospitals & Clinics
Operated By

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

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

If you have a regularly scheduled doctor or clinic appointment, please call your provider to reschedule. For care after hours, please call your provider.

Parents and guardians, please encourage and welcome the involvement of your children in the Wellness Center.

Student Registration Information

Before your student can receive the services offered by the Wellness Center, a pre-enrollmentguardian registration packet must be signed and on file at the center.

If you are interested in volunteering, and you may withdrew your permission at any time in writing.

Please make sure that your contact information is current so we can obtain consent when needed.
Dear Parent/Guardian:

When your consent is required, for us to examine and treat your child you will be contacted for your consent.

If you have any questions about the Center, please call 816-412-6978. The Center, Please call (816) 412-6978.

When you need to contact the Center if you feel your child has been injured or is unwell, please do not attempt to notify the parents or guardians at first. Please do not leave the Center.

An annual consent form must be on file such as for asthma and chronic disease management.

For students registered in the clinic:

Provides the following services for all students:

- Chronic disease management
- Mental health evaluation
- Minor illness & injury
- Sports physicals

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

- Employment

University Academy is a WISE (Workplace Inclusiveness in School Employment) Center.

The Wellness Center provides resources.

The Wellness Center is staffed by trained professionals:

Wellness Center
University Academy

Grade K-5 Registration

Wellness Center
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 ____________/__________/_________
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: __________________________________________________________________
Authorization to Exchange Medical Information

(Front)

Patient Name: __________________________ Medical Record Number: ________________
Street Address: __________________________
City, State, Zip Code: _______________________

Regarding the patient named above, I hereby authorize University Academy Wellness Center 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: 4801 Holmes Rd
City, State, Zip Code: Kansas City, MO 64131
Telephone: 816-412-5978 Fax: 816-302-9638

INFORMATION TO BE EXCHANGED (SPECIFY): Sports physicals, immunization records, 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