RKM PRIMARY CARE CONSENT FOR BEHAVIORAL HEALTH SERVICES
LIVINGSTON PARISH SCHOOL DISTRICT
****STUDENT CANNOT RECEIVE TREATMENT WITHOUT A SIGNED CONSENT****
Please read and sign all pages. Please print using black or blue ink only, do not use pencil.

Student's Name: Last First Middle Initial			ID# (Office use only.)
Student's Address (include city):			Zip Code:
Student's Date of Birth:	Sex at Birth: ❑ M ❑ F Gender Identity:	Age:	School: Grade:
Student's Social Security Number:	RACE: ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawai'ian ☐Guamanian / Chamorro ☐Samoan ☐Other Pacific Islander ☐American Indian / Alaska Native ☐Black / African American ☐White ☐More than one ☐Choose not to disclose		Ethnicity (select all that apply): ☐ Not Hispanic ☐ Spanish ☐ Mexican ☐ Mexican-American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic ☐ Choose not to disclose
Preferred Language:	Parent/Guardian Email:		Student's Cell Phone: ( )
Name of Mother (include maiden name) or Legal Guardian:		Birthdate:	Home Phone: ( ) / Cell Phone: ( )
Name of Father or Legal Guardian:		Birthdate:	Home Phone: ( ) / Cell Phone: ( )
Head of Household:		Number of People in Home:	Household Income: $ / year
Emergency Contact:		Relationship:	Phone: ( )
Student's Primary Care Physician: Please check if the student does not have a Primary Care Provider: ❑			Phone: ( )
Student's Dentist: Please check if the student does not have a Dentist: ❑			Phone: ( )
Preferred Pharmacy:	Names of siblings enrolled in the same school:		

Please check the type of health insurance your child has:

Please send a copy of insurance card (front and back) with this form.

❑ Medicaid/Bayou Health Plan #: _____ (check one below)
❑ Healthy Blue ❑ AmeriHealth Caritas LA ❑ Aetna
❑ LA Healthcare Connections ❑ United Healthcare of LA ❑Humana Healthy Horizons
❑ Private Dental Insurance Co. Name_____
Policy #: _____
❑ Private Medical Insurance Co. Name: _____
Co. Address: _____ Phone #: _____
Policy #: _____ Group#: _____ Effective Date: _____
Name of policy holder: _____ Policy Holder's
Date of birth: _____ Policy Holder Social Security _____
Policy holder relationship to student: _____
Does your insurance pay for prescriptions? ☐ No ☐ Yes
❑ No insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

Is your child allergic to any food or medicine? ❑ No ❑ Yes If yes, list: 1. _____ 2. _____ 3. _____ 4. _____	List of current medications student is on with dosage (how much) and how often: Use separate sheet if necessary. 1. _____ 2. _____ 3. _____ 4. _____

Student Name _____ Student Date of Birth: _____

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE LICENSED MENTAL/BEHAVORIAL HEALTH PROFESSIONAL TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦risk assessment, diagnostic, and other preventative mental health screenings ♦behavioral/mental health counseling services (including health education & prevention programs) which includes individual, family and group therapy as deemed appropriate and suitable for care ♦referral and follow-up for behavioral health emergencies ♦referral to specialty care ♦case management ♦telehealth services ♦Medicaid enrollment assistance

Is your child currently being treated for behavioral health issues? ___ Yes ___ No. If so, please indicate the provider: _____.

Please list any medical and/or mental health diagnosis that your child may have. Also, please note any specific concerns you have about your child's social/emotional/behavioral well-being in the home and/or school environment. _____

_____

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS.

I, as parent/guardian, understand that RKM Primary Care shall bill Medicaid and/or my private health insurance company for any behavioral/mental health services provided. I authorize/assign payments of authorized benefits directly to Primary Care Providers For A Healthy Feliciana, Inc. (PCPFHF).

We also understand that the RKM Mental Health program is operated by Primary Care Providers For A Healthy Feliciana, Inc. and its employees and contractors. Primary Care Providers For A Healthy Feliciana, Inc. is a nonprofit corporation which operates a network of Federally Qualified Health Centers. Primary Care Providers For A Healthy Feliciana, Inc. has partnered through a memorandum of understanding with the Livingston Parish School District to provide mental/behavioral health services to children, families, teachers, and staff. Primary Care Providers For A Healthy Feliciana, Inc. and the FQHCs which they operate and the services which are provided by the FQHCs are governed by a 13-member board which is not under the governance of the Livingston Parish School Board.

I understand that PCPFHF Clinics may provide services via Tele–Health electronic media. I understand that such services will be used only for providing necessary services and that the professionals involved will respect and protect the confidential nature of the sessions. I also understand that if I object to the use of any electronic media for use in treatment, it will in no way jeopardize my relationship with PCPFHF Clinics. Confidentiality/Consent to Release Information: We consent to the exchange of relevant information between school staff and PCPFHF staff as needed for treatment purposes only. We understand that due to the highly confidential nature of services provided by the program, information will only be shared for safety and/or treatment purposes.

I understand that all Primary Care Providers For A Healthy Feliciana, Inc. locations may participate in one or more health information exchanges (HIEs), whereby PCPFHF, Inc. may share health information with my mutual health care providers for treatment, payment, or health care operations purposes. Opt-out information is available at www.rkmcare.org.

I understand that a photograph of the student or copy of the school photo ID will be placed on the student account for identification purposes only.

We (student and parent/guardian) have read, understand, and authorize the services to be provided at the school-based health center. By signing this document, I acknowledge that I am the legal parent/guardian who is authorized to sign treatment/legal documents.

_____ _____
Printed Name of Parent / Legal Guardian (and relationship to student) Date

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Signature of Student Date

This consent is effective while the student is enrolled in his/her current school. The student will need a new enrollment packet completed when he/she progresses to a different school location (Middle to High, Elementary to Middle). This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:
1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

PRIMARY CARE PROVIDERS FOR A HEALTHY FELICIANA, INC

(ALL CLINIC SITES)

NOTICE OF PRIVACY PRACTICES

PURPOSE: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after September 23, 2013 we must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post this Notice in our office in a clear and prominent location where it is reasonable to expect any patient seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient's Name _____ **Patient's Date of Birth** _____

Parent / Guardian Printed Name _____ **DATE** _____

Parent / Guardian Signature _____ **DATE** _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

~Federally Qualified, Not-For-Profit Health Centers~
"The Right Care, Close to Home"

*Christi C. Hunt, Chief Executive Officer * Darie Gilliam, Chief Clinical Officer*

Name: _____ **DOB/Age:** _____ **Today's Date:** _____

Person completing this form and relationship to child: _____

Others living in home and relationship to child: _____

_____

Pediatric Development and Brief Medical History:

Were there any problems or complications during pregnancy (including premature birth)? _____

Please indicate the age your child completed the following milestone:

Walked: _____ Talked: _____ Toilet trained: _____

Has your child been previously diagnosed with a developmental disability? _____

Social Supports:

Who are your child's primary supports (friends, family, pets)? _____

What activities does your child enjoy? _____

What is your religion? Are there any religious/spiritual concerns that are important to know? _____

Are there any racial/ethnic/cultural concerns impacting your child? _____

What are your child's strengths and what do you like about your child's personality, character, or abilities? _____

_____

Academic History:

Current Grade: _____ Has your child ever repeated a grade? Which grade? _____

Please check if your child has: _____ IEP/special education _____ 504 plan

What are your child's current grades? _____

Has your child ever been suspended or expelled? If yes, please explain _____

How many days of school has your child missed this year? _____

How does your child get along with peers? _____

Does your child have any barriers to learning? _____

Trauma History:

Does your child have a history or current experience with: physical abuse/neglect, verbal/emotional abuse, exploitation, domestic violence, sexual abuse, witness to violence, etc? _____

Please detail any social or emotional experiences or stressful events of which you think are important to know when treating your child (divorce, serious accident/illness, death of loved one, natural disaster, witnessed or experienced abuse):

_____

_____

What current stressors is your child experiencing What are the primary concerns that you would like addressed in counseling?

_____

_____

What do you hope will be different for your child or your family by the end of counseling? _____

_____

Mental Health and Medical History:

Please describe past Mental Health Services that your child has received and where/when this treatment occurred? _____

_____

Is your child on any medications? Please list medications. _____

The following are behaviors that may describe how your child acts in the home and/or school setting. Use the scale below to rate each behavior that describes how your child has conducted themselves within the last six months.

N=Never S=Sometimes O=Often A=Almost Always

1.	Worries/fearful	N	S	O	A
2.	Is easily annoyed/easily upset	N	S	O	A
3.	Short attention span	N	S	O	A
4.	Bullies others (can include name calling)	N	S	O	A
5.	Complains about being teased	N	S	O	A
6.	Unable to make friends	N	S	O	A
7.	Unable to maintain friendships	N	S	O	A
8.	Poor self control/Acts without thinking	N	S	O	A
9.	Has expressed suicidal ideation	N	S	O	A
10.	Is negative about things	N	S	O	A
11.	Seeks revenge/makes inappropriate threats	N	S	O	A
12.	Appears withdrawn or prefers to be alone	N	S	O	A
13.	Argues when not able to get their way	N	S	O	A
14.	Displays quick changes in mood	N	S	O	A
15.	Lies excessively	N	S	O	A
16.	Intentionally injures animals/others	N	S	O	A
17.	Appears sad	N	S	O	A
18.	Does not adjust well to changes or transitions	N	S	O	A
19.	Runs away from home	N	S	O	A
22.	Has crying spells	N	S	O	A

Please check off any medical conditions that currently affect your child OR that run in your child's immediate biological family. Put "C" for child, "M" for mother, "F" for father, "S" for sister, "B" for brother, "MGM" for grandmother, "MGF" for Maternal Grandfather, "PGM" for Paternal Grandmother, and "PGF" for Paternal Grandfather.

____ADHD	____Alzheimer's/Dementia	____Anemia
____Anxiety	____Asthma	____Cancer
____Cirrhosis of liver	____Congestive heart failure	____Depression
____Diabetes	____Heart disease	____Hypertension
____Kidney Disease	____Migraines	____Seizure disorder
____Substance Addiction	____Thyroid disease	____Other: _____

Risk Assessment:

Has your child ever talked about wanting to die or made suicidal statements? If yes, please explain. _____

_____

Has your child ever talked about harming another person? _____

Has your child engaged in self-injurious behavior, such as cutting? If yes, please describe. _____

Has your child ever had difficulty with anger management? _____

Does your child have a substance abuse history? Alcohol/Drugs? Describe. _____

Has your child had legal involvement? Please describe. _____

Nutritional Screening:

Has your child had a weight gain or weight loss of 10 or more pounds in the last 3 months?	YES	NO
Does your child have any dental problems?	YES	NO
Has your child had any changes in his/her appetite?	YES	NO
Does your child use bingeing, purging, fasting, or laxatives to control weight?	YES	NO
Does your child have any food allergies?	YES	NO

Health Literacy:

For parent/guardian to complete on themself-

How often do you (parent/guardian) need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

1-Never 2-Rarely 3-Sometimes 4-Often 5-Always