Consent Form

Consent for Care:

Consent will not expire until the Clinic is notified in writing that you wish to revoke.

At Health*First* Bluegrass (HFBG) it is our goal to assist patients in finding their greatest level of wellness. To do so, our provider teams consist of a variety of professionals who work together to improve both physical and emotional health. Regardless of specialty (medical, dental, and behavioral), HFBG provider teams will communicate patient information when clinically necessary.

I give my consent for _____ _____ _____

PATIENT'S FULL NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

To receive any of the following services at Health*First* Bluegrass, Inc.:

1. Treatment may include screening, exams, lab tests, treatment, medicine, behavioral services, and any other studies or procedures that Health*First* Bluegrass professional staff decide are necessary or appropriate.
2. Medical evaluation at Health*First* Bluegrass may also include testing for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids. These tests may be needed for diagnosis; to assist in your medical treatment, or if a health care worker is exposed to your blood, body fluids or tissue.

I give consent for Health*First* Bluegrass, Inc. staff to:

1. Obtain and/or share information and records from outside facilities including primary care practices, specialists, hospital systems, agencies, private professionals, etc.in order to provider appropriate care. HFBG is released from all liability that may arise from the release of such information.
2. Request medication history in the last 2 years through our electronic health record system.
3. Use telemedicine equipment with the service provider being located offsite. These sessions use secure, dedicated high-speed lines in accordance with applicable law, regulations, and guidelines. They are not videotaped, routed through the internet or saved in any way.

In accordance with Federal and State laws, certain types of records that are obtained and/or shared may require an additional release before health information, including psychotherapy notes, can be released.

Electronic communication:

1. Is it okay for HFBG to use an automated telephone message to remind you of your appointment (only a time, date and location will be stated)? **Please initial** **Yes_____No ____**
2. Is it okay for HFBG to contact you with appointment reminders and general communications using text messaging and/or e-mail? **Please initial** **Yes_____ No _____**

HFBG will use your statements, medical history, and other clinical information to evaluate your needs and recommend the best plan of care. No guarantees are being made as to the outcome of any exam or treatment. Please ask your treatment team all questions about risks and benefits of recommended treatments. **I understand that I have the right to and will be given an opportunity to speak to a provider regarding the patient's treatment and any risks.** **Please initial** **Yes_____ No ____**

My signature below confirms my identity and shows that I am giving my consent for treatment. If signing for a minor, my signature confirms that I am the parent or legal guardian and am consenting to the minor's treatment. I understand this consent will remain in effect until revoked. To terminate this consent, I must do so in writing.

_____ _____ _____ _____

Signature of Patient, Parent, Legal Agent/Guardian **Printed Name of Person Signing** **Relationship to Patient** **Date**

Phone Number:_____ **Email:** _____

Privacy Acknowledgement

I understand that Health*First* Bluegrass shall provide a copy of their Notice of Privacy Practices upon my request.

I understand that Health*First* Bluegrass may release patient information WITHOUT permission if: 1) Patient poses a threat to him/herself or others; 2) The patient is unable to protect him/herself from risk of harm; 3) There is evidence of child abuse, neglect, and/or exploitation; 4) There is evidence of dependent adult abuse, neglect, and/or exploitation; 5) There is evidence of domestic violence; 6) Patient information is requested under court order and/or if a patient willingly enters their treatment history into a court proceeding.

Health*First* Bluegrass may be required to share your information if certain legal conditions are met. Health*First* will only share your information when required by law and will only share the minimum amount necessary. For more information, please see the Health*First* Notice of Privacy Practices Form. Health*First* Bluegrass will release your records to your insurance provider for billing and case management.

_____ _____ _____

Date **Signature of Patient, Parent, Legal Agent/Guardian** **Relationship to Patient**

(Revised 4/2024)

HEALTH *FIRST*™ BLUEGRASS

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Patient's Full Name

Consent for Payment

I request that payment of authorized medical insurance benefits be made to Health*First* Bluegrass on my behalf for services received.

I authorize Health*First* Bluegrass to release medical information about me to Medicare, KCHIP, Medicaid insurance and other third-party payers to determine payment for service.

I give my consent for all services listed above. I certify that I am of full capacity to execute the above authorization and release. I agree that the completed information is true to the best of my knowledge. This consent does not expire unless revoked.

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient

Media/Photography Consent

I give consent for Health*First* Bluegrass, Inc. to use my or my child's photograph, likeness and/or voice in any way that would reasonably portray Health*First* Bluegrass, Inc. I release Health*First* Bluegrass, Inc. and any of its employees or agents from any damages in using my or my child's photograph, likeness, and/or voice. This includes but is not limited to photographs for the patient's medical record. Your photo will be taken for chart identification. Photos may also be taken for clinical documentation purposes. Photos are housed within your chart.

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient

School Based Clinics

HealthFirst Bluegrass has several clinics located within elementary, middle, and high schools in Fayette County. HealthFirst Bluegrass School clinics are full-service clinics which are open to the community in addition to servicing the students who attend those schools. The goal of the School Based Clinics (SBCs) is to assist in your child's overall well-being. Partnered with FCPS, information sharing of pertinent medical, behavioral, dental and school health will occur between appropriate FCPS staff and SBC staff.

I give consent for my child to receive any of the following services at Health*First* Bluegrass, Inc. School-Based Clinics, including the dental mobile services.

1. Physical assessment and treatment of acute and chronic illnesses, including administration of prescription and over-the-counter medications; annual physical exams and immunizations, referrals to outside agencies that may not be provided at HealthFirst, health education regarding physical, mental and sexual health.
2. Basic laboratory tests (when needed to assess problems) such as a finger stick for anemia and blood sugar, urine test for bladder or kidney infection, throat swab/strep screen for sore throat, etc.
3. Dental diagnostic procedures including clinical exams, fluoride treatment, cleanings, x-rays (as needed). I understand that certain risks and complications may happen if my child has these procedures. These possible problems include the possibility of discomfort during & following treatment, aspiration or swallowing a dental instrument or dental material, allergic reactions to dental materials, bleeding and other possible problems the dentist cannot predict.
4. Staff to review my child's full school record, including attendance and other information that will assist the staff in the continuity of care and treatment of my child; Communicate and disclose pertinent medical, behavioral health, dental, and school health information with appropriate Fayette County School Staff in regard to my child's success at school and in the school setting.
5. Have my child participate in on-going evaluations of the SBC program, including questionnaires and surveys. I understand that my child will not be identified in the evaluation.

Consent for health services at school clinic:

Do you give consent for your child to receive health services without an individualized notification each time prior to receiving treatment or being referred for these services? **Please initial** **Yes**____ **No**____

Consent for preventative dental procedures on HFBG dental mobile:

Do you give consent for your child to receive preventative dental services (screenings, cleanings, fluoride treatment and x-rays)

Please initial **Yes**_____ **No** _____

Consent for mental health services at school clinic:

Do you give consent for your child to receive mental health services without an individualized notification each time prior to receiving treatment or being referred for these services? **Please initial** **Yes**____ **No**____

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient

HEALTH *FIRST*™
BLUEGRASS

For Pediatric Patients Only:

Outreach Dental Clinic Consent

The Health*First* Bluegrass dental team visit several Fayette County Public Schools to provide both preventative and restorative dental care.The mobile clinic typically visits schools once per semester for a few days at a time. They offer all facets of dentistry, including cleanings, sealants, fluoride treatments, restorations (fillings), and extractions. Our goal is to bring the dentist to you, limiting the need for missing work or your child to miss school for a dental appointment. If you child attends a school where we provide dental care, and they are scheduled to be seen by the dental team, you will be contacted verbally prior to the appointment.

I give my consent for _____ _____ _____

PATIENT'S FULL NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

To receive any of the following services at Health*First* Bluegrass, Inc. Dental Clinics, including the Mobile Clinic:

1. Diagnostic and treatment procedures including clinical exams, fluoride treatment, cleanings, x-rays, silver and/or white fillings, stainless steel crowns, nerve treatment, soft tissue removal, and all local anesthesia by authorized agents and employees of Health*First* Bluegrass and the dental staff, or their designees, as may in their professional judgment be deemed necessary or beneficial. I understand that certain risks and complications may happen if my child has these procedures. These possible problems include: The possibility of discomfort during and following treatment, aspiration or swallowing a dental instrument or dental material, allergic reactions to dental materials, and other possible problems that the dentist cannot predict.

I understand that:

1. My child may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
2. When baby teeth are removed, it can cause problems for the erupting teeth and my child may need a space maintainer to keep the space open for the permanent tooth to come in. I also understand that space maintainers are not placed as a part of this program and that a referral letter will be sent home if necessary.
3. There also may be instances when treatment on a tooth cannot be immediately performed, but in order to prevent an abscess or further infection, the staff may place a topical fluoride to stop the active decay process. While there are no health risks involved, black or dark staining of the decayed surface will occur.

I authorize Health*First* Bluegrass dental personnel to apply this material at their discretion. Please initial Yes____ No____

4. These services will be provided by the dental faculty, students, hygienists and/or staff of Health*First* Bluegrass.
5. The preventive treatment (cleaning, fluoride and sealants) may be provided by a registered dental hygienist without the presence of the dentist, as outlined in general supervision legislation.
6. The dental findings for all the children as a group may be reported on and/ or published, and that, in this case, no child will be identified individually.
7. There may be instances where the DMD is unable to save a tooth when trying to restore it. In these instances, the only alternative is to extract (pull) the tooth. There are risks involved with having teeth removed. While infrequent, these risks may include: pain, excessive bleeding, infection, swelling, bruising, jaw stiffness, damage to adjacent or underlying teeth, breaking of a root tip, etc.
8. While all the individual records are held by Health*First* Bluegrass, Inc. as confidential, I understand that a list of children who need follow-up dental treatment is routinely provided to the school's Family Resource Center, so that they may assist with getting follow up care, when needed.

I authorize HealthFirst Bluegrass staff to share my child's name with the Family Resource Center at their school.

Please initial Yes____ No____

_____ _____ _____

Date **Signature of Patient, Parent, Legal Agent/Guardian** **Relationship to Patient**