



## SCHOOL-BASED HEALTH SERVICES

"A Partner in Student Wellness"

Clarity Healthcare provides primary care and behavioral health services in several school districts in our region. Our School-Based Health Services bring needed care to where kids spend a majority of their day; their school. Our collaboration with school districts helps students to thrive in and out of the classroom environment.

### Current School-Based Services

- Acute primary care appointments such as; cough, cold, sore throat, ear infection, rash, warts, and pink eye.
- Strep testing
- Flu testing
- Diabetes management
- Asthma management
- Allergy management
- Well-Child visits
- Sports physicals
- Therapy
- Behavioral health medication management
- Crisis services
- Vaccinations
- Staff education
- Student education

*Check with your child's school regarding specific services offered in your district.*

### Registering for Services

Enrollment paperwork can be obtained at your child's school, on Clarity Healthcare's website or completed electronically (via email).

*\* Filling out the paperwork does not mean your child will be treated without your consent. You will be contacted prior to any services that are provided to your child.*

### Cost

Clarity Healthcare accepts many insurance and provides a sliding fee scale for those without insurance. If a student qualifies for free or reduced lunch at school, there is no out of pocket expense for the services.

### FAQ

- A student will not be seen by our provider without parent/guardian consent.
- If your child becomes sick at school, the school nurse will contact you to see if you want your child seen at school.
- You have the option to stay at work, come to the appointment, or join via phone or telehealth.
- The provider can send any prescriptions to your pharmacy.
- The provider will call you with updates after the appointment.

To find out about services offered at your school: P: (573) 603-1460 Ext: 2326.

To schedule an appointment for therapy services: P: (573) 603-1460 Ext: 2365.

WEBSITE: [www.clarity-healthcare.org](http://www.clarity-healthcare.org)

EMAIL: [help@clarity-healthcare.org](mailto:help@clarity-healthcare.org)

SPARTAN CLINIC: (660)-225-1188

EMAIL: [spartanclinic@pfh.org](mailto:spartanclinic@pfh.org)

Check out The Spartan Clinic Facebook Page! <https://www.facebook.com/SpartanClinic>



School-Based Health Services  
"A Partner in Student Wellness"

### Clarity Healthcare/Preferred Family Healthcare School-Based Billing

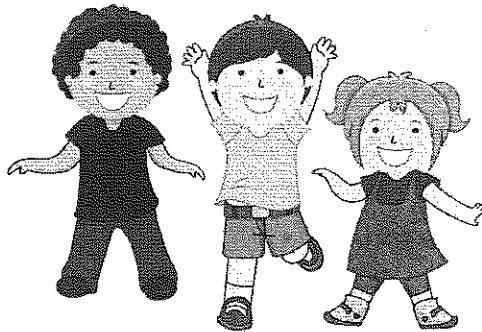
- If your child has insurance, the insurance will be billed for services.
- A sliding scale is available for those with or without insurance.
- If your child receives free/reduced lunch at school, services are free.
- If you have insurance and your child has free/reduced lunch, your insurance will be billed, but you will not have any out of office expense.
- If you get an explanation of benefits from your insurance, that is not a bill.
- If you get a bill from Clarity and have any questions about it, call our billing department at 573-603-1460, ext. 2380.

*Well-visit checks are an important part of a child's overall wellness.*

- Well-visit checks help track milestones, growth and development, and social behaviors.
- Well-visit checks are an opportunity for parents to discuss any health concerns they have for their child.
- A well-visit appointment can take place at the school-based health center clinic through Clarity Healthcare.
- Parents don't have to miss work. Parents can call in for the visit, join via telehealth, or be updated by the provider after the appointment.
- To schedule an appointment in Hannibal, call the PATCH Center at 573-719-3247.
- To schedule an appointment in Moberly, call the Spartan Clinic at 660-570-1453.
- Other school districts call 573-603-1460 ext. 2326 to see if this is provided in your school district and to schedule an appointment.

#### *What to expect during a well-child visit*

- Determine whether your child has any health concerns.
- Offer ways to keep your child from developing health concerns
- Provide support for your child's overall physical and behavioral health
- Talk through health information, answer your questions, and offer advice



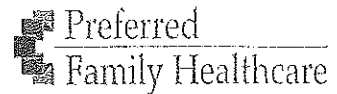
**CLARITY**  
*Healthcare*

School-Based Health Services  
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(Please Print)

Today's Date:		Primary Care Provider:	
<b>Patient Information</b>			
Patient Name (Last, First, Middle):		Mr. Ms. Mrs. Miss	Former Name(s):
Is this your legal name? Yes No		If not, what is your legal name?	
Sex: Male Female Other	DOB:	Age:	Social Security #:
Primary Phone #:	Secondary Phone #:	Email Address:	
Street Address:			P.O. Box:
City:		State:	ZIP Code:
Patient Occupation:	Patient Employer:	Employer Phone #:	
School Currently Attending (If Child):		Does child receive free/reduced lunches: Yes No NA	
<b>Spouse/Guardian/Parent Information:</b>		Address:	Phone #:
Name:			
<b>Guardian/Parent Information:</b>		Address:	Phone #:
Name:			
<b>Insurance Information (Please give your insurance card to the receptionist)</b>			
Person Responsible for Bill:	Birth Date:	Address (If different):	Primary Phone #:
Is this person a patient here? Yes No		Patient relationship to subscriber: Self Spouse Child Step-Child Other	
Occupation:	Employer:	Employer Address:	Employer Phone #:
Primary Insurance: Medicare Medicaid Blue Cross Blue Shield United Healthcare Other: _____			
Subscriber Name:	Subscriber SSN:	Birth Date:	Co-Payment:
	Policy #:	Group #:	\$
Secondary Insurance (if applicable):	Subscriber Name:	Policy #:	
		Group #:	
Patient relationship to subscriber: Self Spouse Child Step-Child Other			
<b>In Case of Emergency</b>			
Name of local friend or relative (not living at the same address):		Relationship to patient:	
Primary Phone #:		Secondary Phone #:	



The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of Preferred Family Healthcare/ Clarity. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

**Please check one box in each of the following categories:**

<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Other (Specify): _____	<b>Gender Identity:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Decline to Disclose	<b>Sexual Orientation:</b> <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Don't Know <input type="checkbox"/> Decline to Disclose
<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White (not Hispanic or Latino) <input type="checkbox"/> Hispanic or Latino (all races) <input type="checkbox"/> Decline to Disclose	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	<b>Housing Status:</b> <input type="checkbox"/> Own/Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter <input type="checkbox"/> Permanent Supportive	<b>Employment Status:</b> <b>Patient:</b> <input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> Unemployed <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <b>Spouse:</b> <input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> Unemployed <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal
<b>How did you hear about Preferred Family Healthcare/Clarity?</b> <input type="checkbox"/> Referral (Friend/Family) <input type="checkbox"/> Referral(Physician) <input type="checkbox"/> Billboard <input type="checkbox"/> Magazine <input type="checkbox"/> Newspaper <input type="checkbox"/> Social Media <input type="checkbox"/> Health Fair <input type="checkbox"/> Other (Specify): _____		<b>Advance Directives:</b> Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is your health care agent? _____	
<b>Family Members: For the protection of your confidentiality, do you have any family members who work at Preferred Family Healthcare/Clarity?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____			

**List ALL members of the household. Include all persons living in the household (related or non-related):**

Name:	Relationship:

**Sources of Income:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Gross Wages/Salaries/Tips                    | <input type="checkbox"/> Welfare Benefits             | <input type="checkbox"/> Veteran's Benefits  |
| <input type="checkbox"/> Unemployment Compensation                    | <input type="checkbox"/> Social Security              | <input type="checkbox"/> Regular Contributions from person not living in the household |
| <input type="checkbox"/> Worker's Compensation                        | <input type="checkbox"/> Supplemental Security Income | <input type="checkbox"/> Any other income not included in the above list               |
| <input type="checkbox"/> Earnings from need-based employment programs | <input type="checkbox"/> Survivor's Benefits          |  |
|   | <input type="checkbox"/> Pensions                     |  |

**Total Annual Household Income:** \$ \_\_\_\_\_

I have read and completed the attached form and certify the information I entered is true and complete to the best of my knowledge. In addition, I have provided verification or provided self-attestation of all household income sources in order for this application to be processed. I understand completion of this form does not guarantee a discount, and if I do not qualify for a discount, I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform Preferred Family Healthcare/Clarity at my next visit. I also agree to provide updated income verification as often as possible. All information submitted will remain confidential. I understand if I qualify for the sliding scale program, there may be a minimum payment required per appointment. **(Signature of this form serves as acknowledgement)**

*(For Internal Use Only):*

Based on the information above, you qualify for \_\_\_\_\_ on the sliding fee scale and will be charged \$ \_\_\_\_\_ per  visit  month.

Staff Signature (if applicable): \_\_\_\_\_



## Acknowledgement & Consent to Treat

The below statements apply to all healthcare providers providing services through Preferred Family Healthcare/Clarity. They include services provided by employees, contractors, agencies or other entities affiliated with Preferred Family Healthcare, Inc. Please read carefully and be sure that you understand each statement below; we will be glad to answer any questions that you may have. Signature of this form serves as acknowledgement of the following:

**Insurance and Patient Responsibility:** Insurance claims are submitted on your behalf by Preferred Family Healthcare/Clarity. Deductibles and copays are due at the time of check-in. Clients are not responsible for any copays or deductibles that accrue from participation in the TAX program. You are responsible for knowing your insurance coverage and if our providers are in-network or not in-network with your insurance plan. For any questions regarding your coverage, we recommend you contact your carrier or plan provider directly. You will need to update or verify personal information at each visit and show your current insurance card. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file or are unable to verify your benefits, you will be considered a self-pay patient. As a self-pay patient, a minimum fee (as determined by location) may be expected to be paid at the time of service. If you can provide your insurance card and the insurance pays your claim in full, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled.

**Assignment of Benefits:** The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Preferred Family Healthcare/Clarity. I understand I am financially responsible for any balance. I also authorize Preferred Family Healthcare/Clarity or my insurance company to release any information required to process my claims.

**Release of Information for Billing:** I authorize Preferred Family Healthcare/Clarity to release medical and billing information for the purpose of payment collection to all parties responsible for payment on my behalf including the entities listed above under insurance information, and Substance Use Disorder funding sources including The Department of Health & Human Services, and the following (as applicable):

<p><b><u>Missouri:</u></b></p> <ul style="list-style-type: none"> <li>•United States Probation &amp; Pretrial Services Western District of Missouri</li> <li>•Community &amp; Children's Resource Board of St. Charles County</li> <li>•Franklin County Children &amp; Families Community Resource Board</li> <li>•State of Missouri Department of Social Services</li> <li>•Children's Services Fund of Jackson County</li> <li>•Jordan Valley Community Health Center</li> <li>•St. Louis County Children's Service Fund</li> </ul>	<ul style="list-style-type: none"> <li>•St. Louis Mental Health Board</li> <li>•Missouri Foundation for Health</li> <li>•Missouri Department of Mental Health</li> <li>•Office of State Courts Administrator</li> <li>•12th/45th Circuit Treatment Court</li> <li>•9th/41st Circuit Treatment/Drug Court</li> <li>•Community Foundation of the Ozarks</li> </ul>	<p><b><u>Illinois:</u></b></p> <ul style="list-style-type: none"> <li>•Adams County Probation</li> <li>•Pike County Probation</li> </ul> <hr/> <p><b><u>Kansas:</u></b></p> <ul style="list-style-type: none"> <li>•United Community Services of Johnson County</li> </ul>
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The information released will be limited to that needed to collect payment and may include release of alcohol or drug abuse (if applicable) information. Authorization includes the release of preadmission, recertification, and appeal information which may include diagnosis, symptoms, treatment plans, test results, or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable). This consent will stay in effect until the account is settled.

**Notice of Privacy Practices:** I acknowledge I have been offered a copy of the Notice of Privacy Practices.

**Consumer/Program Orientation:** I acknowledge I have been offered a copy of the Consumer Orientation Guide/Program Handbook. I understand the consumer rights and responsibilities, services offered, treatment planning, emergency service availability, request for change and grievance procedures. I further understand I may request additional copies of the Consumer Orientation Guide/Program Handbook from any PFH office or provider at any time.

**Confidentiality Practices:** I understand my records of treatment will be kept confidential and released only with a signed consent form except when required by law. Providers of services have a duty to protect, warn and/or report the following:  
•Threat of harm to self •Threat of harm to others • Abuse, neglect or exploitation of children and/or vulnerable adults, including acts of domestic violence.

**Photo Consent:** I give my consent to have a photo taken for office identification purposes. This photo will be kept confidential and stored in my electronic medical record. I understand having a photo on file may be mandatory for programs in which medications are staff and/or self-administered and failure to do so may prevent program participation.



**Substance Use Disorder Records:** I understand substance use disorder records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse and can only be disclosed with 1) My written consent 2) A court order 3) To qualified personnel for a medical emergency, research, audit, or program evaluation 4) In reference to a threat or crime committed at the program or against program personnel or as otherwise provided for in the regulations. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. (See 42 USC 290dd-3, 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

**Medications:** I permit Preferred Family Healthcare/Clarity to store and manage my medications while in residential/RCF/PSR programs including prescription, over-the-counter, and those delivered to or brought on-site. I understand Preferred Family Healthcare/Clarity will administer or observe my self-administration of medications. I agree to allow Preferred Family Healthcare/Clarity or its designated representatives to provide over-the-counter medications such as Ibuprofen, Acetaminophen, Chewable Antacids, and topical medications and pick up/accept delivery of medications ordered for me from the pharmacy as well as disposal of medications if they are discontinued by the physician or I leave Against Medical Advice.

**HIE:** Preferred Family Healthcare/Clarity may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your healthcare providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STI treatment and test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at [pfh.org/privacy](http://pfh.org/privacy) or you may call us at 1-855-450-5770. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

**Communicable Disease Reporting:** Unless being seen for symptoms of a contagious virus or illness such as COVID-19, SARS, or Influenza A/B, I affirm I do not have current symptoms, current or recent diagnosis, nor have I resided with or been in close proximity to anyone who I have knowledge of having been diagnosed with a contagious illness. Should my health condition change or I become aware of an exposure, I am to report this to my Preferred Family Healthcare/Clarity provider immediately. I consent to allow Preferred Family Healthcare/Clarity to report communicable diseases to the Department of Health and Senior Services as outlined by the agency, including cooperation with investigations and providing client information as requested. I acknowledge Preferred Family Healthcare/Clarity recommends I wear a mask at all times when present within their facility(ies). Some facilities may allow me to opt out of wearing a mask. This is subject to change at any time as determined by site leadership based on current local conditions and CDC recommendations. I agree to release Preferred Family Healthcare/Clarity of any liability should I contract COVID-19, Influenza A/B, SARS, or any other contagious illness.

**Medical and Psychiatric Advance Directives:** I permit Preferred Family Healthcare/Clarity to obtain emergency medical and/or psychiatric treatment deemed necessary for my physical and mental health unless otherwise specified through written consent. I understand I will be responsible for payments not covered under insurance benefits for these services. I also give permission to Preferred Family Healthcare/Clarity and other healthcare entities of which I receive services to share necessary medical information for healthcare and payment purposes.



Please indicate your consent to the following by checking the box on the left:

Exercise: Some Preferred Family Healthcare/Clarity programs include recreation and physical exercise. I consent to participate in these activities at my own risk. I understand Preferred Family Healthcare/Clarity and its representatives shall not be liable for any claims arising out of participation. If there is a reason I cannot participate, I understand it is my responsibility to notify program staff.

A.R.T. - C: I understand I may be given opportunities to participate in the Achieving Recovery Through Creativity (A.R.T.-C) program throughout treatment. I hereby assign, transfer and convey all of my right title and interest in any art I create, in whole or in part, during my participation, to Preferred Family Healthcare/Clarity. I understand photographs and reproductions of my projects may be used as marketing and fundraising materials including but not limited to brochures, newspapers, posters and cards. I understand no additional consideration will be owed to me for any of these purposes.

Public/Media Opportunities: I understand I may be given opportunities to participate in public contests, shows or community activities which may result in photographs and/or press articles. I may also be given opportunities to be interviewed, photographed and/or videotaped to share my personal story or experiences with Preferred Family Healthcare/Clarity, for the purpose of creating educational or marketing materials, which may then be distributed broadly throughout the community. Participation in the above-mentioned opportunities may disclose personal information to the public such as my name and hometown as well as my involvement in treatment. Once materials are distributed, there is no guarantee the information will not be picked up by the media or be posted on the internet. Preferred Family Healthcare/Clarity, it's affiliates, and employees are not legally responsible or liable for the re-disclosure of the information. I understand these opportunities are in no way mandatory and my voluntary agreement and participation constitutes implicit consent.

Telehealth: I understand there may be services available to me through participation in Telehealth and that participation in these services is not mandatory and I will be informed of alternative resources for needed care. I can refuse to participate in Telehealth services at any time without affecting my right to future care through Preferred Family Healthcare/Clarity. Telehealth services are subject to the same confidentiality laws as services provided in person and there will be no dissemination, storage, or retention of video interaction produced during Telehealth services. I will be informed of all parties who are present during the Telehealth service and I have the right to exclude anyone at my request. I will be provided with emergency contact information should a mental health or medical emergency arise.

Alternative Communication Methods: Preferred Family Healthcare/Clarity will at times need to communicate with me about my protected health information, the care I receive, my bill, and other services. These communications may include, but are not limited to, refill and appointment reminders, scheduling requests, and referrals. I understand Preferred Family Healthcare/Clarity may contract with other organizations to manage or collect for the services provided to me. This consent extends to telephone communications by these organizations as well. I understand that use of wireless telephone and email may increase the risk of inadvertent or unauthorized disclosure of my information to third parties. I understand I am responsible for protecting any information I receive and consent to receive communication through the following (Please Indicate): Phone call Text Message Email All

I have read and understand the above. I have been informed and understand the nature of the services provided by Preferred Family Healthcare/Clarity and my right to request discharge if at any time I do not wish to continue services and treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: Parent Legal Guardian Other (specify): \_\_\_\_\_

Would you like a copy? Yes No



## Medical History Form

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

**Medications** (please list drug name, dose and how often it is taken):

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**Preferred Pharmacy:** \_\_\_\_\_

**Allergies** (please list any allergies you have and the reaction they cause):

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Are your immunizations up to date? Yes No

If no, what immunizations are missing? \_\_\_\_\_

<b>Tobacco Use:</b> Which best describes you?			
	Current tobacco user Type _____	How long have you used tobacco?	
	Former tobacco user Type _____	How long did you use tobacco?	
	Never a tobacco user		

<b>Patient History:</b> Have you been diagnosed with any of the following:			
High blood pressure		Heart Disease	
Cancer (type _____)		Diabetes	
Thyroid disease		Asthma	
Seizure disorder		Stroke	
COPD/Emphysema		Anemia	
Other:		Other:	

Please list any ER visits, hospitalizations or surgeries and approximate date (if known):

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Family Medical History	
Disease	Family Member
Heart Disease Type _____	
Diabetes	
High Blood Pressure	
Mental Illness Type _____	
Anemia	
Glaucoma/Eye Disorder	
Arthritis	
Stroke	
Seizures	
Thyroid Disease	
Cancer Type _____	
Kidney Disease	
Other	