Child's Name:_____ Date of Birth:_____

Parent Name (please print):_____ Phone Number:_____

Consent to Treatment

I hereby give my consent for my child to receive services offered by the providers and clinical staff on the Crossing Healthcare Mobile Unit. Services may include, but are not limited to:

Pre-K through High School

- Physicals vaccinations and health screen
- Minor illness and injuries
- Disease management (ex. diabetes, asthma)
- Medical referrals and follow up
- Point of care testing
- Weight management
- Health education and promotion
- Nutrition counseling
- Assessment of stress/emotional problems
- Individual counseling
- Dental services (available April 2020)

Junior High and High School only

- Pregnancy tests
- Birth control
- STI diagnosis, treatment, education and counseling

I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian or student who is permitted to under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing Crossing Healthcare Mobile Unit providers to provide services to my child in his/her best interest. I understand that I may need to be contacted by phone during my child's visit on the Crossing Healthcare Mobile Unit and care may not be provided if I cannot be reached and the provider needs additional information to properly treat my child. I understand that I may need to obtain medications or other care related items to continue treatment of my child. I further understand under Illinois law, minors, including those age 12 and older, under specific circumstances, have the same capacity as an adult to consent to certain health services and no parental permission is required for such services

I consent to the release of relevant health information and medical records in connection with treatment by the Crossing Healthcare Mobile Unit providers to collaborating partnerships to facilitate my child's healthcare needs. I authorize Crossing Healthcare Mobile Unit staff to release my child's immunization record and copy of any Certificate of Health Examination form completed by Crossing Healthcare Mobile Unit staff to Decatur Public Schools District 61. I authorize Decatur Public Schools District 61 to release immunization records to Crossing Healthcare Mobile Unit.

Parent/Responsible Party Signature: _____ Date: _____

Relationship (if not the patient):_____

Assignment of Benefits

I assign to Crossing Healthcare all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for medical care and treatment provided by Crossing Healthcare.

Payment Agreement

I authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I agree to notify Crossing Healthcare of any changes in my name, address, phone number or other personal information including all insurance information.

Patient/ Responsible Party Signature: _____ Date:_____

Relationship (if not the patient):_____