

May 5, 2026



Dear EastSide Families,

We are excited to share a new partnership between EastSide Charter School and Westside Family Healthcare. Westside is a community health center located just a few minutes from the school that has served the Wilmington community for nearly 40 years. Together, we are bringing quality healthcare directly to EastSide students through a new School-Based Health Center (SBHC).

The SBHC is now open and will have hours available for appointments on Mondays, Wednesdays, and Fridays during the school year. It is located next to Nurse Dottie's office. This center is more than just a place for check-ups. It is a space where students can feel supported, cared for, and ready to thrive both in the classroom and in life.

In this packet, you will find information about the services offered at the SBHC, including primary care services, preventive care, and coordination with your child's existing healthcare provider.

There is no cost for care provided at the school-based health center, though Westside may bill your insurance if you have coverage.

To enroll your child in the School-Based Health Center, please complete and return all forms in this packet. Completed packets can be returned to the SBHC team or to Nurse Dottie.

We understand that it can be challenging to find time for doctor visits. This program helps by:

- Bringing care directly to your child during the school day
- Saving you time and reducing missed appointments
- Helping your child stay healthy and ready to learn

We are proud to partner in support of the health and success of every EastSide student. Thank you for welcoming this program into your school community. If you have any questions, please do not hesitate to reach out.

Sincerely,

Aaron Bass
Chief Executive Officer
EastSide Charter School

Chris Fraser
President & Chief Executive Officer
Westside Family Healthcare

About Westside Family Healthcare:

Westside Family Healthcare brings nearly 40 years of experience caring for patients throughout Delaware, providing primary care medical, behavioral health, and dental services to over 25,000 Delawareans. Westside operates five health center locations in Wilmington, Bear, Newark, and Dover. The closest site to EastSide Charter School is located just a mile away at 908 E. 16th Street next to New Destiny Fellowship along the Brandywine River.

To learn more, please visit www.westsidehealth.org.

SCHOOL-BASED HEALTH CENTER (SBHC) REGISTRATION PACKET FOR STUDENTS

EastSide Charter School-Based Health Center

3000 N. Claymont St.
Wilmington, DE 19802
Phone: (302) 224-6800

Westside Family Healthcare

We treat you well.

Dear Parents/Guardians:

The School-Based Health Center (SBHC) is a partnership between Westside Family Healthcare and EastSide Charter School. This letter is an invitation to sign up your child in the SBHC.

Healthcare in the SBHC is provided by a team of healthcare providers. An Advanced Practice Clinician, a Medical Assistant, a Behavioral Health Counselor, and a Health Resources Coordinator provide care at your child's school.

To sign up your child in the SBHC, you need to provide the following:

- Up-to-date insurance information is needed if your child is insured. (Note: No co-pay, co-insurance, or deductible will be charged to you, and no one will be turned away based on ability to pay.)
- A completed Consent Form (included in this packet).
- A completed Student Registration Form and Health History Form (included in this packet).

The completed enrollment/registration forms should be returned to the SBHC as soon as possible.

SBHC services offered:

- Physicals
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses and injuries
- Counseling (individual)
- Crisis intervention and suicide prevention
- Health education/risk reduction

Your child's pediatrician or family doctor will still be their main primary care provider. The SBHC does not replace your child's doctor. Instead, SBHC providers work together with your child's doctor to keep your child healthy.

The SBHC can provide extra services to support your child's health. When needed, we may share health information with your child's doctor. This helps avoid repeated services and makes sure your child gets the best care. If your child does not have a doctor, we can help you find one.

We hope that you will register your child for the SBHC. By working together—with you and your child's doctor—we can help keep your child healthy and ready to learn. If you have questions or want more information, please call the SBHC.

PATIENT (STUDENT) CONSENT FOR SERVICES (AGES 5-11)

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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Student Name _____ Date of Birth ____/____/____

Street Address _____ City _____ State _____ Zip Code _____

Services Provided by the School-Based Health Center:

- Health assessments
- Vaccines
- Diagnosis and treatment of medical problems
- Referrals to and follow-up for oral, vision, and/or specialty care
- School-Based Health Center administered mental health and substance use disorder assessments, crisis intervention, counseling, and treatment.
- Referral to mental health and substance abuse services, including emergency psychiatric care, community, and support programs

Services Not Provided by the School-Based Health Center:

- Treatment or testing of complex health and mental health problems
- Complex lab tests
- Hospitalization
- X-Rays
- Emergency Care (except to stabilize for transfer to Emergency Department, if needed)

In consenting to permit my child to participate in the School-Based Health Center, I acknowledge and agree to the following:

- I have had the opportunity to review Westside Family Healthcare's Notice of Privacy Practices (NPP). I understand that the full Notice of Privacy Practices is available upon request.
- **I understand** that insurance may be billed for covered services, and I agree to provide insurance information before services are provided.
- **I understand** that the School-Based Health Center does not charge co-pays or any other out-of-pocket fees for use of School-Based Health Center Services.
- **I give** Westside permission to contact me at any phone number I provide — including cell phones — for healthcare-related calls or texts. This may include automated calls or messages. Giving this permission is not required to receive care. This consent applies to all Westside services until I cancel it in writing.
- **I understand** that the School-Based Health Center may use telehealth to provide services, including medical, mental health, and Health Resource Coordinators. Telehealth encounters are subject to the same protection under the HIPAA Privacy Rules as a face-to-face visit.
- **I understand** that telehealth means getting healthcare by video call, phone, or secure messaging instead of an in-person visit.
- **I understand** that telehealth visits have benefits (convenient, no travel needed) and some risks (connection problems, rare privacy concerns). If there is a technical problem during a visit, the provider will follow up by phone or reschedule. If it is an emergency, I should call 9-1-1.
- **I understand** that my child's privacy is protected during telehealth visits just like during in-person visits. Westside will not record, data store, or archive any visit without my permission. This is required by a federal law called HIPAA.
- **I understand** that Delaware law requires the SBHC to share certain health information with the Delaware Division of Public Health (DPH). This includes things like some test results, STI diagnoses, and reports of

**PATIENT (STUDENT) CONSENT
FOR SERVICES (AGES 5-11)**

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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abuse or neglect. These reports are required by law to protect public health. Some general data is also shared for tracking purposes, but your child's name is removed from that information.

- **I understand** this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. I understand that any requests in writing must be sent to the School-Based Health Center associated with my student's care.
- **I agree** that school staff can accompany my child for medical exams.
- **I acknowledge** that all information on the Health History Form and this consent is accurate and complete.
- **I understand** that information sharing between the SBHC and Eastside Charter School requires separate signed authorizations, which are included in this packet.
- **I understand** that care at the School-Based Health Center may be provided or observed by supervised learners as part of their clinical training. Learners may include, but are not limited to, medical assistant students, nurse practitioner students, and behavioral health students. All learners work under the close supervision of a licensed provider. I have the right to request that no learner be present during my child's visit, and this will not affect the care my child receives.

I have read this form carefully. All my questions have been answered to my satisfaction. I understand that I may call the School-Based Health Center if I have any questions before or after I sign this consent for services.

By signing below, I certify that I am the parent or legal guardian of the student named above and have read the above consent statements about services offered at my child's School-Based Health Center and voluntarily agree to have my child participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

I give consent for my student to receive health services at the EastSide Charter School School-Based Health Center administered by Westside Family Healthcare.

(Signature of Parent/Guardian)

(Printed Name)

(Relationship to Student)

(Date)

APPOINTMENT OF DECISION MAKER FOR MINOR

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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Student Name _____ Date of Birth ____/____/____

As the parent or legal guardian of this student, I appoint the following to be decision maker(so) for my child in my absence.

Name of Decision Maker	Relationship to Child
X _____	X _____
I authorize the above decision maker to give consent for treatment of the following: ☐ Routine health maintenance (physical exams) ☐ Medical care of illness ☐ Immunizations (sign consent for shots) ☐ X-Rays and laboratory tests	

Name of Decision Maker	Relationship to Child
X _____	X _____
I authorize the above decision maker to give consent for treatment of the following: ☐ Routine health maintenance (physical exams) ☐ Medical care of illness ☐ Immunizations (sign consent for shots) ☐ X-Rays and laboratory tests	

Name of Decision Maker	Relationship to Child
X _____	X _____
I authorize the above decision maker to give consent for treatment of the following: ☐ Routine health maintenance (physical exams) ☐ Medical care of illness ☐ Immunizations (sign consent for shots) ☐ X-Rays and laboratory tests	

I am authorizing the person(s) named above to bring my child for medical care and treatment. This appointment of alternate decision maker expires on: ____/____/____ (or the child's 18th birthday if no date indicated). To cancel this appointment of the decision maker, please provide this office with written notification.

(Signature of Parent/Guardian)

(Printed Name)

(Relationship to Student)

(Date)

(Witness Signature)

(Witness Print Name)

(Date)

**APPOINTMENT OF DECISION MAKER
FOR MINOR**

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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FOR HEALTH CENTER STAFF USE ONLY:

TELEPHONE CONSENT:

(Name of Parent/Guardian giving consent)

(Relationship to Student)

(Witness Signature)

(Date)

(Witness Signature)

(Date)

PATIENT REGISTRATION

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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Patient (Student) Information

Grade: ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th

Student's Last Name: _____ **First:** _____ **Middle Initial:** ____

Preferred First Name: _____ **Date of Birth :** ____ / ____ / ____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Race: (mark all that apply)

- ☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Black or African American
☐ More than one race
☐ Asian
☐ White
☐ Declined to Provide
☐ Other Race: _____

Ethnicity: (mark all that apply)

- ☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Declined to Provide

Biological Sex (for clinical purposes — mark one):

- ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to answer ☐ Other

Gender Identity (mark all that apply):

- ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to answer ☐ Other

Primary Care Physician: (Family Doctor)

Name: _____

Phone Number: _____

Preferred Pharmacy:

Name: _____

Phone Number: _____

In case of an emergency contact:

Relationship to Student: _____

Name: _____

Phone Number: _____

Student's Cell Phone Number:

Information Need for Program Requirements

Primary Language: _____

Is the student registered homeless? ☐ Yes ☐ No

Is anyone in the family an Agricultural Seasonal Worker? ☐ Yes ☐ No

Is anyone in the family an Agricultural Migrant Worker? ☐ Yes ☐ No

By federal regulations, Westside Family Healthcare must assess patients for a sliding fee scale.

Family Size: _____

Estimated Annual Family Income: \$ _____

PATIENT REGISTRATION

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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Parental/Legal Guardian Information

Mother's Full Legal Name: _____ Date of Birth: __ / __ / ____
Address: _____ Home Phone #: _____
Email Address: _____ Cell Phone #: _____
Employer Name & Address: _____ Work Phone #: _____

Father's Full Legal Name: _____ Date of Birth: __ / __ / ____
Address: _____ Home Phone #: _____
Email Address: _____ Cell Phone #: _____
Employer Name & Address: _____ Work Phone #: _____

Legal Guardian: (If not mother or father) Date of Birth: __ / __ / ____
Name: _____ Home Phone #: _____
Address: _____ Cell Phone #: _____
Email Address: _____ Work Phone #: _____
Employer Name & Address: _____

Insurance Information (REQUIRED) – Send a Copy Front and Back of Insurance Card

**Source of payment for care,
please check one of the following:**

- ☐ No Insurance
- ☐ Medicaid Provider: _____
Medicaid Number: _____
- ☐ Commercial Insurance: _____
Policy Number: _____
Subscriber Number: _____
Relationship to Student: _____
Subscriber Birthdate: __ / __ / ____
- ☐ Delaware Healthy Children Program

Secondary Insurance Information:

- ☐ No Insurance
- ☐ Medicaid Provider: _____
Medicaid Number: _____
- ☐ Commercial Insurance: _____
Policy Number: _____
Subscriber Number: _____
Relationship to Student: _____
Subscriber Birthdate: __ / __ / ____
- ☐ Delaware Healthy Children Program

(Signature of Parent/Guardian)

(Printed Name)

(Relationship to Student)

(Date)

HEALTH HISTORY FORM

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
We treat you well.

A complete and accurate health history is needed so that Westside Family Healthcare can provide high quality care. Please print all information and complete this form as much as possible.

Student's Name: _____
(Last Name) (First Name) (MI) (Date of Birth)

Grade: ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th

Does your child have any allergies? (i.e., food, medication, latex)

☐ Yes ☐ No

If yes, please list:

Please provide the following information about medicines your child is taking.

Name of medicine:	Reason taken:	How long taken:

Primary Care Provider Name: _____

Date of Last Physical: ____ / ____ / ____

Please check which of the following your CHILD has ever had:

- | | | |
|---|--|--|
| ☐ Acne/Skin Problems | ☐ Headaches | ☐ Seasonal Allergies |
| ☐ ADHD/learning disability | ☐ Head Injury | ☐ Seizures |
| ☐ Anemia | ☐ Heart Disease | ☐ Sickle Cell |
| ☐ Anxiety | ☐ Heart Murmur | ☐ Sleeping Problems |
| ☐ Asthma | ☐ Hemophilia | ☐ Sports Injury |
| ☐ Cancer | ☐ Hepatitis | ☐ Stomach/Intestinal Problems |
| ☐ Chicken Pox | ☐ High Blood Pressure | ☐ Suicide Attempts |
| ☐ Cystic Fibrosis | ☐ High Cholesterol | ☐ Suicidal Thoughts |
| ☐ Diabetes | ☐ Kidney/Bladder Disease | ☐ Substance Abuse |
| ☐ Depression | ☐ Pregnancy/Child Birth/Miscarriage | ☐ Thyroid Disease |
| ☐ Fainting Spells | ☐ Rheumatic Heart Disease | ☐ Tuberculosis |
| ☐ Frequent Colds | ☐ Scoliosis | |

If any of the above is checked, please give more detail:

HEALTH HISTORY FORM

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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Has your child ever been hospitalized or received counseling for emotional or behavioral health?

☐ No

☐ Yes When: _____ Where? _____
Reason: _____

Please check any of the following illnesses that your FAMILY MEMBERS (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and write in which family member next to the illness

- | | |
|--|--|
| ☐ ADHD/learning disability: _____ | ☐ Hepatitis: _____ |
| ☐ Alcoholism/Drug Abuse: _____ | ☐ High Blood Pressure: _____ |
| ☐ Anemia: _____ | ☐ High Cholesterol: _____ |
| ☐ Arthritis: _____ | ☐ Kidney/Bladder Disease: _____ |
| ☐ Asthma: _____ | ☐ Mental Illness: _____ |
| ☐ Birth Defects: _____ | ☐ Obesity: _____ |
| ☐ Cancer: _____ | ☐ Seizures: _____ |
| ☐ Cystic Fibrosis: _____ | ☐ Sickle Cell: _____ |
| ☐ Deafness: _____ | ☐ Stroke: _____ |
| ☐ Diabetes: _____ | ☐ Thyroid Disease: _____ |
| ☐ Headaches: _____ | ☐ Tuberculosis: _____ |
| ☐ Heart Disease: _____ | ☐ Unexplained Death: _____ |
| ☐ Hemophilia: _____ | ☐ Other: _____ |

(Signature of Parent/Guardian)

(Printed Name)

(Relationship to Student)

(Date)

CONSENT FOR TREATMENT AND PRIVACY INFO

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
We treat you well.

CONSENT FOR TREATMENT

My signature below confirms my consent to Westside Family Healthcare ("Westside") to conduct the following activities on behalf of the above-named patient (the "Patient"):

- General medical and/or dental care: Examination, diagnosis, and routine treatment
- Diagnostic testing: Laboratory tests (ex. Blood), imaging (ex. X-rays), and other diagnostic procedures
- Additional information: Provision of information by allied health professionals (social services, nutritionists, nurses, and care coordinators) to improve my health outcomes
- Routine procedures: Immunizations, blood draws, vital sign monitoring, and similar standard procedures
- Furnishing information from the Patient's medical record to any insurer, compensation carrier, or any agency that may be providing financial assistance for medical care

I understand that:

- I agree to provide true and accurate information about my medical history, current health conditions, medications, allergies, changes in health status, and any other information relevant to my care.
- My provider will use their professional judgment when providing care.
- There is no guarantee as to a specific health outcome for care or treatment provided.
- My healthcare providers will make reasonable efforts to inform me of any significant risks and benefits associated with proposed treatments.

NOTE: Some procedures require separate, specific informed consent. These include but are not limited to invasive procedures such as minor surgical procedures, certain biopsies, gynecological procedures, and dental procedures, as well as other procedures with potential risks. Your provider will discuss these procedures with you and obtain separate written informed consents when needed.

CONSENT FOR EMERGENCY MEDICAL CARE

In the event of a medical emergency occurring at this office, I consent to receive immediate, stabilizing treatment as necessary until I can be safely transferred to an appropriate facility.

PATIENT RIGHTS

I understand that:

- I have the right to ask questions about any aspect of my care or treatment.
- I have the right to refuse specific treatments at any time.
- I can request a second opinion.
- I can withdraw my consent for treatment at any time, except for emergency care, by notifying the office in writing.

I acknowledge that:

- Westside provides a detailed Patient Rights and Responsibilities document.
- Patient Rights and Responsibilities are posted at every health center site and available upon request.

CONSENT FOR TREATMENT AND PRIVACY INFO

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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PATIENT PRIVACY

HIPAA Notice of Privacy Practices

In compliance with HIPAA federal privacy requirements, Westside Family Healthcare maintains the privacy of protected health information and only uses and discloses it as allowed by law. You may revoke such permission at any time by writing to our Privacy Officer (contact info below).

You can request a copy of our detailed Notice of Privacy Practices or access it on our website at westsidehealth.org/westside-family-notice-of-privacy-practices/

Coordination with School

- I give permission for my child's health care team to share information with and discuss my child's health and school performance with my child's school as needed and as permitted by law.
 - School staff: School Nurse, School Social Worker(s), School Behavioral Health Staff, School Administrators and Teachers (when clinically relevant), as employed by EastSide Charter School
 - Health care team members): Westside Family Healthcare — EastSide Charter SBHC staff
- I understand that allowing my child's health care team to share information with my child's school will allow them to coordinate my child's care, provide outreach services if necessary, and keep my child healthy, safe, and engaged in school.
- I understand that, even with this consent, *only* those individuals at my child's health care office and school who *must* have access to information about my child to provide necessary services will be permitted to participate in discussions or data sharing regarding my child.
- I understand that, whenever possible, my child's health care provider will include me in discussions about my child.
- I understand that I am entitled to receive a copy of any disclosed records via the medical records department.
- I understand that these individuals may further use records provided by my child's healthcare provider or school for contacting me and/or verifying information for student health related purposes.

This consent will remain in effect until my child stops being a SBHC patient or is no longer enrolled at ESCS, unless I cancel earlier. I may revoke this consent at any time by submitting a note or letter in writing to my child's health care office.

Participation in an Organized Health Care Arrangement (OCHIN)

Westside Family Healthcare Inc. is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Westside Family Healthcare, Inc., OCHIN supplies information technology and related services Westside Family Healthcare, Inc., and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. Your personal health information may be shared by Westside Family Healthcare, Inc. with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement.

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. You have the right to change your mind and withdraw this consent;

CONSENT FOR TREATMENT AND PRIVACY INFO

School-Based Health Center (SBHC) for Students
Kindergarten through Eighth grades

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Westside Family Healthcare
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however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided with a list of entities to which your information has been disclosed.

I acknowledge that:

- Westside provides Notice of Privacy Practices, which describes how my personal health information (PHI) may be used and disclosed, as well as my rights related to my PHI.
- The Notice of Privacy Practices is available on the Westside website.

Deidentified Data

I authorize Westside to share my deidentified medical and other information concerning my care with others for purposes of survey, study, or research, if all personal identifying information (PII) about me has been removed.

Westside Family Healthcare's Privacy Officer

If you have patient privacy concerns, or to revoke your consent for Westside's use or disclosure of your protected health information, contact our Privacy Officer.

Privacy Officer
300 Water Street
Wilmington, DE 19805
Telephone No.: (302) 656-8292
Fax No.: (302) 656-8982

CONSENT FOR TELEMEDICINE SERVICES

I understand that I may be offered telemedicine options as an alternative to in-person visits. Telemedicine may involve digital platforms, video conferencing, and other virtual tools to provide access to my provider and will be provided in accordance with Delaware law.

I understand that, before each telemedicine visit:

- My provider's identity and credentials will be disclosed and verified.
- My identity and physical location in Delaware will be verified.
- I must be physically located in Delaware at the time of telemedicine services (required by Delaware law).
- I am aware that operating a motor vehicle while engaging in telemedicine communications poses a significant risk to the safety of myself and others. I agree not to operate a motor vehicle while engaging in telemedicine sessions.

I consent to receive telemedicine care and acknowledge that:

- The standard of care for telemedicine will be the same as for in-person care.
- Telemedicine visits will be documented in my medical record just as in-person visits are.
- Not all conditions can be diagnosed or treated through telemedicine.
- There may be limitations on prescribing certain medications through telemedicine.
- Technical difficulties may occur, and, if the connection fails, my provider will contact me by phone or reschedule the appointment.

CONSENT FOR TREATMENT AND PRIVACY INFO

School-Based Health Center (SBHC) for Students
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Westside Family Healthcare
We treat you well.

- Alternatives are available, including in-person visits, which may involve additional travel or scheduling time.
- I am responsible for having the necessary technology, privacy, and internet connection for my telemedicine visits.
- I am responsible for payment of services in the same manner as for in-person care.
- I may stop telemedicine services at any time and request an in-person visit instead, without penalty.
- My provider will use secure, HIPAA-compliant technology that meets federal and Delaware privacy and security requirements.
- My confidentiality will be protected, though I understand there are risks and limitations to using electronic communications, including possible technical failures or privacy breaches.

CONSENT FOR USE OF DIGITAL HEALTH TOOLS AND ARTIFICIAL INTELLIGENCE (AI)

As part of my care, I consent to Westside's use of digital health tools and artificial intelligence (AI) to assist the care team in providing better care to me. These may include clinical decision support tools, diagnostic assistance software, electronic health record (EHR) systems with AI-assisted features, and care coordination and communication platforms.

- AI tools assist Westside healthcare providers but do not replace their professional and clinical judgment. Final treatment decisions are always made by qualified healthcare professionals.
- Patient information used by these AI tools is protected under federal privacy laws, including HIPAA.
- AI tools are intended to enhance safety, efficiency, and quality of care, but, like any technology, may have inherent limitations.

FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION

I assign and authorize payment of all insurance benefits to Westside.

I can ask in writing that Westside does not bill my insurance if I pay in full for the services. If I do, I can also request in writing that my medical information is not shared with my insurance company or anyone else.

I give Westside my permission to access state or insurance provider systems to determine my eligibility of health care access programs or other medical assistance benefits.

AUTHORIZATION AND SIGNATURE

By signing below, I confirm that I have read and fully understand this Consent for Treatment form. I have had the opportunity to ask questions, including requesting this form in another language, and all my questions have been answered to my satisfaction. I consent to receive treatment as described and understand that this consent will remain effective until revoked in writing. I have provided and will continue to provide true and accurate information to Westside.

(Signature of Parent/Guardian)

(Printed Name)

(Relationship to Student)

(Date)