Pueblo Community Health Center

Your Health. Our Mission.

School-Based Wellness Centers

Pueblo Community Health Center (PCHC) welcomes students and parents/guardians to the new school year. In partnership with Pueblo School Districts 60 & 70, and CHPA, PCHC is responsible for School-Based Wellness Centers (SBWCs) at several schools in Pueblo County.

PCHC will see any student regardless of their ability to pay. Please see the section on financial responsibility on the "Consent to Treatment and Disclosure" on the back of this page.

Before any student can be seen we require a signed Student Consent completed by their parent/guardian. This consent will remain in force until the student leaves his/her school, or until the parent/guardian directs the SBWC to cancel it. It is the parent's/guardian's responsibility to notify the school about changes in guardianship.

Once a consent form is on file, a student is welcome to be seen at ANY SBWC site. Parents/guardians with questions about SBWC services are encouraged to contact PCHC at (719) 543-8711.

Locations

Centennial High School
2525 Mountview Drive
Pueblo, CO 81008

Central High School
216 East Orman Avenue
Pueblo, CO 81004

Chávez/Huerta K-12 Preparatory Academy
2727 West 18th Street
Pueblo, CO 81003

East High School
9 MacNeil Road
Pueblo, CO 81001

Pueblo County High School
1050 Lane 35
Pueblo, CO 81006

Pueblo Community College
The Student Health Clinic
900 West Orman Avenue, MT 118
Pueblo, CO 81004

Services

Exams
- Sports, school & camp physicals
- PCP follow-ups
- Acute injury & illness
- Common concerns (acne, weight, menstruation)
- Testing & treatment of STDs

Education
- Parent & student health
- Drug & alcohol prevention

Counseling
- Drug & alcohol use
- Individual, group & families
- Nutritional
- Family planning

Other
- Lab tests (limited)
- Prescriptions (limited)
- Coordination of medical & behavioral health treatment
- Preventative dental care

Financial Assistance

Insurance is accepted for services provided by the School-Based Wellness Center. In the event the student is not covered by insurance, we will provide treatment based upon the parent's/guardian's completion of a Financial Eligibility application.

Co-payments and/or deductibles will be assessed and collected. If your child is referred to a hospital, specialist or other health care provider, additional charges are the responsibility of the parent/guardian. Immunization fees are separate.

CONSENT TO TREATMENT AND DISCLOSURE

Student (Patient) Name: _____

Date of Birth: _____ **Phone Number:** _____

Pueblo City/County Schools and Pueblo Community Health Center have established a School-Based Wellness Center (SBWC) program to provide primary health care and behavioral health services to its students. Services provided through the SBWC program include, but are not limited to, diagnostic treatment and services, individual and family therapy, patient education, and administration of immunizations (immunizations may require a *separate* consent). I voluntarily request and consent to the rendering of health care and behavior care services by the SBWC, its staff, and providers. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

Parental/ Guardian involvement and notification. Colorado law may prohibit the SBWC and its providers from informing parents/guardians of mental health problems, substance abuse issues, eating disorders, pregnancy matters, family planning, including birth control, and diagnosis or treatment of sexually-transmitted diseases without the patient's permission. For the purpose of these conditions, the patient may enter into a confidential and privileged relationship with the SBWC provider. However, it is the SBWC's practice to attempt to gain permission from the patient to inform his/her parent(s), guardian, or a caring adult when one or more of these conditions are present. When permission is not granted, the SBWC staff will strongly encourage the student to communicate their condition to their parent(s) and/or guardian. Parents, guardians, or other authorized representatives with questions about SBWC services are encouraged to contact the SBWC with their inquiries.

Confidentiality and release of information. I hereby authorize the SBWC to release information from the patient's medical records for treatment, payment, healthcare operations, and other purposes as permitted by applicable state and federal law, including the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including to any health care provider, the school's nursing staff, and other SBWC staff who is involved in any way with the care of the patient and to any person or entity which is or may be liable for all or part of the charges for services, goods, or facilities provided to the patient. I understand that following release of this information, the SBWC cannot control its confidentiality. I also give consent to and authorize the SBWC staff to examine the patient's school records, attendance, and other records as necessary to assist the SBWC staff with the patient's diagnosis and treatment. I understand refusal to authorize disclosure of the patient's health information to a health benefit plan (including health insurance, discount benefits program, government health programs, etc.) will have no effect on my enrollment, eligibility for benefits under the SBWC program.

Financial responsibility and assignment for direct payment. I hereby authorize the SBWC and its providers to bill any health benefit plan (including health insurance, discount benefits program, government health programs, etc.) that may be responsible for providing coverage and/or payment for service provided to the patient by the SBWC. In the event the patient does not have health care coverage, the SBWC and its providers will provide treatment and services and the parent/guardian will be responsible for any charges. The parent, or guardian may complete a financial eligibility screening to determine if the patient qualifies for any health care assistance programs that help with the cost of the patient's care. I hereby authorize payment to be made directly to the SBWC and its providers, not to exceed the amount of their regular charges, otherwise payable to me for my health care services, good, and facilities provided. I understand that there is no guarantee of reimbursement from any health benefits plan or other payer and that I may be financially responsible for all charges not paid for any reason by my health benefit plan or other payer within a time period the SBWC deems reasonable. Co-payments and/or deductibles associated with any health benefit plan will be assessed and collected. In addition, it may be necessary to refer the patient to the hospital, specialists, or other health care providers for recommended treatment in order to provide quality health care. These providers may have separate charges for these services which will be the responsibility of the student/parent/guardian and are not covered by this consent form.

Acknowledgement and termination of this consent form. I understand this consent will remain in force until the patient is no longer enrolled at the patient's current school. I also understand that I may revoke this authorization at any time, in writing, except to the extent that the SBWC has already acted on my permission. It is the parent/guardian's responsibility to notify the SBWC about changes in guardianship.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM, UNDERSTAND ITS CONTENTS, AND HAVE RECEIVED A COPY HEREOF. I ACKNOWLEDGE THAT I HAVE REVIEWED PUEBLO COMMUNITY HEALTH CENTER'S PRIVACY NOTICE. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT OR A PERSON AUTHORIZED BY THE PATIENT OR OTHERWISE TO SIGN AND ACCEPT THIS AGREEMENT AND CONSENT ON BEHALF OF THE PATIENT.

_____ _____

DATE **SIGNATURE OF PATIENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE**

_____

PRINT NAME

Authorized Use Only
Staff Initials: _____ Dept: _____
New Patient: ☐ Yes ☐ No
FPT ☐ FHT ☐ IZ's ☐ SBWC Non-Medical ☐

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