McDonald County School District

FREEMAN Health System

Consent to Treatment and Agreement to Pay for Such Treatment

Name of Student/Patient:_____

I have read and I agree to the following consent and financial agreement:

I give consent for medical treatment by a licensed provider who may be a physician or an advanced practice registered nurse employed by Freeman Health System ("Freeman") for medical care to the Student/Patient named above. I understand that services are available without discrimination prohibited by federal and state law. If consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless an emergency exists or care is allowed by Missouri law. This consent shall be in accordance with the standard Freeman Consent to Treatment form, which is incorporated herein by reference, a copy of which can be obtained from the School named above ("School") or any Freeman facility.

Should it be necessary that the Student/Patient be transported to a Freeman facility for treatment I may consent to the School providing such transportation, if available, in accordance with school policy.

I understand that the Information in my (if I am an adult or a consenting minor under Missouri law) or my child's medical record is confidential and will not be released to any unauthorized person or agency without consent.

I agree to be financially responsible for all medically necessary services provided to me or to the Student/Patient under this consent. I hereby assign to Freeman any and all benefits payable from any insurance plan covering the Student/Patient and request that such benefits be paid directly to Freeman, which will be applied to the charges for services rendered. I agree to the terms of the standard Freeman Financial Agreement, which is incorporated herein by reference, a copy of which can be obtained from the School or any Freeman facility. I understand that I MUST provide Freeman with a current copy of my health insurance card or I will be charged as a "self-pay" patient. I will notify Freeman if my health insurance changes and I will provide a copy of any new health insurance card to Freeman.

I understand that Freeman may disclose all or any part of the Student's/Patient's medical record to any insurance company, pharmaceutical manufacturer, medical services company or person which is or may be responsible for payment under a contract for charges made.

I authorize Freeman to disclose all or any portion of my (if I am an adult or a consenting minor under Missouri law) medical record to my child's primary care provider, who is _____.

I authorize Freeman to disclose all of my (if I am an adult or a consenting minor under Missouri law) or my child's immunization record to the School.

I authorize Freeman to obtain copies of my (if I am an adult or a consenting minor under Missouri law) or my child's school records, including any medical records that may be on file with the School, if such records will assist the medial staff in providing the necessary care for my child. The School may rely on this authorization in providing requested copies of school records.

Please complete other side.

With my signature, I certify that I understand the above agreement and that I am authorized to sign for the Student/Patient.

Date:_____

_____

Signature of parent or legal representative of Student/Patient or of Student/Patient if the Student/Patient can consent to his/her care under Missouri law.

_____

Relationship to Student/Patient

_____

Address and Phone Number

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For Nursing Use Only
Telephone/Verbal Consent

The person responsible for the care of the Student/Patient, namely _____ (insert name of parent or legal representative) has been fully informed of the provisions set forth above and has verbally authorized me to sign this form on their behalf in order of the Student/Patient to receive needed care.

_____

Name, position and contact information for person signing