YUKON-KUSKOKWIM HEALTH CORPORATION
P.O. Box 287 • Bethel, Alaska 99559 • 907-543-6000

Bethel Regional High Health Center

Parent/Guardian Consent and Insurance Information Sheet

Student's Name _____ DOB_____

Address_____ City, State, Zip_____

Insurance Information: ☐ Medicaid ☐ Other Insurance:_____

Policy Holder _____ Policy number or ID number_____ Group Number_____

Parent's Employer_____ Effective date_____

ASSIGNMENT OF INSURANCE BENEFIT: *I assign the Yukon-Kuskokwim Health Corporation, all benefits due and payable to me under insurance policies by virtue of my treatment. I authorize insurance company to deduct payments from its obligations to me for benefits provided under my policy. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I understand that I remain financially responsible to YKHC for charges not met by the proceeds of this assignment, if I am not IHS eligible. I agree to pay all charges for all services rendered to me during my treatment at YKHC that are not paid in full by any third party payers.

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES: *I authorize Yukon-Kuskokwim Health Corporation to disclose medical information i.e. diagnosis, discharge summary, doctors' orders, progress notes and other related documents to the extent required to assure payment to any agency. , who is liable. This would include the diagnosis, or treatment received during the course of this treatment.*

PRIVACY ACT*: I understand that the information given by me and/or collected and stored in my health record or any portion of my health record may be shared with other service providers within YKHC and as necessary to ensure the highest quality of services available for my health and wellbeing. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person without my signed consent, unless the disclosure is permitted by federal/state laws and regulations. (Notice of privacy practices is available upon request or you can download a copy at YKHC.org)*

This form makes it possible for your child to receive health services through the Bethel Regional High Health Center until they are 18 years old. All direct care is provided by a YKHC or Bethel Public Health Center provider. We are proving these services to improve access to care for teens in the community.

This consent form provides you with two options:

I acknowledge that I have read this agreement and understand its purpose and contents.

I PROVIDE MY CONSENT.

I am the parent or legal guardian of the minor individual whose name is stated above. I hereby give my consent to the Bethel Regional High Health Center to provide health and counseling services to my child throughout the school year.

Signature _____ Relationship_____

Printed name:_____ Date_____

I acknowledge that I have read this agreement and understand its purpose and contents.

I WITHHOLD MY CONSENT.**

I am the parent or legal guardian of the minor individual whose name is stated above. I DO NOT give my consent to the Bethel Regional High Health Center to provide health and counseling services to my child.

Signature _____ Relationship_____

Printed name:_____ Date_____

Note: *You may submit a new form if you decide at a later date to provide consent.*

If you provided your consent please provide the following information:

Name of Child's regular physician: _____

Past or present chronic illness if any:_____

Allergies or reactions to medications if any:_____

***** Alaska law AS 09.65.100(4) states that a minor may give consent for diagnosis, prevention or treatment of pregnancy, and treatment of venereal disease. No parental consent is required for these services.***