NORTH CEDAR
ACADEMY

Hello,

I am the School Nurse at North Cedar Academy (NCA) and I look forward to meeting your child. My first and foremost concern is the health and well-being of our students, staff and the Ladysmith community.

It is important you complete all the necessary health forms included in the welcome packet to ensure your child's health in the event of illness or emergency. **Please complete the following forms and return to NCA 4 weeks prior to your child's arrival.** This allows me time to review the forms and records. It is very important to list any allergies, medications, nutrition/dietary restrictions, dental needs, mental health concerns and any recent surgeries. Please include any treatments or follow-up needs. We at NCA follow confidentiality protocol closely.

The following forms need to be completed and returned to NCA:

1. NCA Students and Parent Information Form
2. Student Medical Information
3. Authorization of Non-Prescription Medications
4. Standing Orders for Medication Administration
5. Authorization of Prescription Medications
6. Marshfield Clinic Health System Sharing of Information
7. Marshfield Clinic Health System Consent of Treatment of Minors in Parent/Legal Guardian Absence
8. Marshfield Clinic Health System Consent Treatment
9. OakLeaf Clinics Authorization for Treatment of a Minor
10. OakLeaf Clinics Family Shared Information
11. OakLeaf Clinics Written Acknowledgement of Receipt
12. OakLeaf Clinics OakLeaf Clinics Notice of Privacy Practices
13. OakLeaf Clinics Patient Financial Responsibility, Assignment of Benefits, & Authorized Representative Agreement
14. Rusk County Public Health Vaccination Information and Vaccine Requirements (Vaccines are administered free of charge from the local Health Department)
15. Student Immunization Record (you may submit vaccines records from your physician in English)
16. Wisconsin Immunization Registry Vaccine Administration Record

Immunization records are extremely important. The State of Wisconsin has mandated laws for students attending private and public schools must have on file the required vaccines to maintain compliance in the State of Wisconsin. If you choose to waive (refuse) immunizations due to health, religious or personal reasons you must indicate on the Student Immunization Record Step 4, which vaccines. If the waiver is due to health reasons, a physician or health care provider must sign and date the form.

Please note if a student has incomplete immunizations, students may be excluded from classes if an outbreak occurs. If you have any questions please feel free to contact me at NCA at 715-532-0201, Ext 230 or email me at ckrings@northcedar.net.

Sincerely,

Cynthia A. Krings RN

Cynthia A. Krings RN, BSN

1500 Port Arthur Road, Ladysmith, WI 54848
Phone: 715.532.0201 Fax: 715.532.9916

NORTH CEDAR ACADEMY

Student and Parent Information

Complete ALL fields. Mark 'N/A' (Not Applicable) where appropriate.

STUDENT INFORMATION

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Email address	Cellphone

WeChat	WhatsApp	Languages Spoken at Home

PARENT / GUARDIAN INFORMATION (1)

First (Given) Name	Middle Name	Last (Family) Name	Date of Birth (MM/DD/YYYY)

Relationship to Student	Email address	Emergency Phone Number

Cellphone	WeChat	WhatsApp

Languages Spoken at Home:	Interpreter Needed (circle one): YES NO

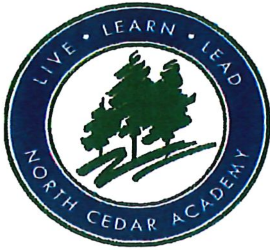
PARENT / GUARDIAN INFORMATION (2)

First (Given) Name	Middle Name	Last (Family) Name	Date of Birth (MM/DD/YYYY)

Relationship to Student	Email address	Emergency Phone Number

Cellphone	WeChat	WhatsApp

Languages Spoken at Home:	Interpreter Needed (circle one): YES NO



NORTH CEDAR ACADEMY

Student Medical Information

If you are a returning student updating your medical information, please only mark changes that have occurred since your last day of attendance. If you require additional room for explanation, please use the back of this form.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

Primary Contact Preferred Communication (phone number, email address)

Allergies (foods, medication, insects, contacts, etc) **& Symptoms of Reactions**

____

____

Physical Restrictions

____

____

History	Yes	No	History	Yes	No
Heart Condition	❑	❑	Dental Braces	❑	❑
Diabetes	❑	❑	Depression	❑	❑
Asthma	❑	❑	Anxiety	❑	❑
Epilepsy	❑	❑	Sleep Disorder	❑	❑

Other Conditions (please describe in detail)

____

____

Are you currently taking any medications? ❑ Yes ❑ No

NORTH CEDAR ACADEMY

Authorization for Administration of NON-PRESCRIPTION Medication

This form is for non-prescription medication that your child will be bringing with them to campus. All medications must be administered to students by trained North Cedar Academy staff.

One (1) form PER MEDICATION is required.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

Parent's Statement

1. Reason for medication:
2. Name & type of medication:
3. Dosage/amount to be administered:
4. Frequency/times of dosage:
5. Duration (week, month, indefinite, etc.)

Parent/Guardian Request and Approval

I hereby request and give my permission for the designated staff of North Cedar Academy (NCA) to administer the non-presciption medication on this form to my child. I further exonerate the designated staff of NCA from any liability resulting therefrom. I shall inform NCA of any changes in my child's health or medication(s). **It is the policy of NCA that medication be brought to school in the original container. Any medicine not in the original container will not be dispensed.** ***All international medication must be identified in English and with the appropriate dosage.*** The Authorization for Administration of Non-Prescription Medication is valid until the student withdraws, transfers, or graduates from NCA.

Parent's Signature: ____________________ **Date:** __________

NORTH CEDAR ACADEMY

Standing Orders for Medication Administration

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

These medications will be administered by NCA staff to students for the listed symptoms. If there is a medication that you do NOT want your child to receive, please mark the box (☒) next to the name of the medication. Medications that cause allergic reactions should also be listed on the Student Medical Information form. This form is valid until the student withdraws, transfers, or graduates from NCA.

Allergies: ❑ Loratadine (Claritin) - 10 mg 1 tablet daily for sneezing and runny nose
❑ Benadryl - 25mg 1-2 capsules every 6-8 hours as necessary for sneezing and runny nose

Cold & Congestion: ❑ Pseudoephedrine - 30mg 1 tablet every 4-6 hours PRN for nasal congestion

Car Sickness: ❑ Dramamine - 1 tablet every 8 hours (should be administered prior to a long bus/car ride)

Constipation: ❑ Miralax - 1 cap full in 8 ounces of clear liquids daily

Cough: ❑ Robitussin - (generic dextromethorphan) 2 tsp (10cc) every 4-6 hours as needed for cough
❑ Cough drop - 1 every 2-3 hours

Cuts/Abrasions/Scrapes/Burns: ❑ Triple Antibiotic Ointment - 2-3 times per day as needed; cover with band--aid and assess for infection

Diarrhea: ❑ Imodium - 2 tablets following the 1st loose stool; 1 tablet every 8 hours as needed for diarrhea

Digestion/Gas/Stomach Discomfort: ❑ Tums - 2 chewable tables every 4 hours as needed for upset stomach and heartburn

Eye Irritation: ❑ Artificial Tears - 2-3 drops to each eye as needed

Fever: ❑ Tylenol Extra Strength - 2 tablets every 4 hours for fever

Headaches: ❑ Ibuprofen - 200mg 2-3 tablets every 4-6 hours (will not be administered if stomach is empty) or
❑ Tylenol - 500mg 1-2 tablets every 4-6 hours

Menstrual Cramps: ❑ Ibuprofen - 200mg 2-3 tablets every 4-6 hours as necessary
(will not be administered if stomach is empty)

Pain/Aches/General Discomfort: ❑ Acetaminophen (Tylenol) - 500mg 1-2 tablets every 4-6 hours

Rash/Itching: ❑ 1% Hydrocortisone Cream - Topically 3-4 times daily

Parent's Signature: ____________________ **Date:** ____________________

NORTH CEDAR ACADEMY

Authorization for Administration of **PRESCRIPTION** Medication

This form is for prescription medication that your child will be bringing with them to campus. All medications must be administered to students by trained North Cedar Academy staff.

One (1) form PER MEDICATION is required.

First (Given) Name	Middle Name	Last (Family) Name	Preferred Name (Nickname)

Date of Birth (MM/DD/YYYY)	Primary Contact	Relationship

PART I - Physician's Statement

1. Reason for medication:
2. Name & type of medication:
3. Dosage/amount to be administered:
4. Frequency/times of dosage:
5. Duration (week, month, indefinite, etc.)
6. Possible side effects/symptoms of medication:
7. Contact me should the following occur:

Physician's signature:	Date:
Physician's address:	Phone number:

PART II - Parent/Guardian Request and Approval

I hereby request and give my permission for the designated staff of North Cedar Academy (NCA) to administer the medication prescribed on this form to my child, and I authorize them to contact the child's physician if necessary. I further exonerate the designated staff of NCA from any liability resulting therefrom. I shall inform NCA of any changes in my child's health or medication(s). **It is the policy of NCA that medication be brought to school in the original container. Any medicine not in the original container will not be dispensed.** *All international medication must be identified in English and with the appropriate dosage.*

Parent's Signature: ______________________ **Date:** ______________

Marshfield Clinic Health System

Clear Form

Patient Name:	MRN:	DOB:	Sex:

Sharing of Information Authorization

1. Patient Information

Name:	Date of Birth	
Address	Phone #	
City	State	ZIP

2. Health Care Facility who has the information you want released

☑ **Marshfield Clinic Health System - All Locations (**excludes all Family Health Center Locations)**

3. Who you want the information shared with

Please list the name, relationship & phone # for individuals you want information shared with:

Name	Relation	Phone #
North Cedar Academy Staff		715-532-0201

Please list the name of organization/facility you want information shared with:

ORGANIZATION/FACILITY North Cedar Academy

Address 1500 Port Arthur Road City Ladysmith State WI ZIP 54848

Contact Person North Cedar Academy Staff Phone # 715-532-0201

4. Information to be shared

☑ Medical Information including appointment verification **(excludes mental health, AODA treatment & HIV test results)** -- may leave messages on voicemail

☑ Two way communication information ☑ Billing information (may include health information)

☐ **Specific Information:** Diagnosis:

Provider: Date Range:

Records Requiring Specific Consent:

The applicable records must be checked in order to be released

- ☐ Psychological Testing
- ☐ Mental Health Treatment Notes
- ☐ AODA Treatment Notes
- ☐ Neuropsychology Notes
- ☐ HIV/AIDS Results
- ☐ Genetic Testing Results

Records Requiring Minor Consent: ***The applicable records must be checked in order to be released***

- ☐ Outpatient AODA (12+yrs)
- ☐ Inpatient AODA - Detox Only (12+yrs)
- ☐ Outpatient mental health care (14+yrs)
- ☐ Inpatient mental health care (14+yrs)
- ☐ Neuropsychology notes (14+yrs)
- ☐ Rape or sexual assault/abuse (12+yrs)
- ☐ Sexually transmitted disease (17+yrs)
- ☐ Pregnancy test (17 yrs or younger)
- ☐ Birth control pills (17 yrs or younger)
- ☐ Pregnancy-related care or care of newborn (17 yrs or younger)
- ☐ HIV/AIDS test results (14+yrs)

Patient signature Date/Time

Additional Permissions Granted:

☐ Access to "My Marshfield Clinic" portal - incudes my Marshfield medical record number (MRN) for access

☐ Relative who is a physician at MCHS may access my electronic medical record (*i.e., spouse, child, etc*)

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Patient Name:	MRN:	DOB:	Sex:

5. Expiration	This authorization will remain in effect: ☐ Until you cancel this authorization in writing ☐ From the date of signature until the following date: ____________ ☑ Until the following event occurs: patient withdraws, transfers or graduates from North Cedar Academy ***This form will no longer be valid upon the death of the patient***

My signature authorizes the use and disclosure of the information I have selected above. I acknowledge that I have reviewed and understand this authorization form, including the notices below.

Patient Signature	Date/Time	Printed Name

Signature of Authorized Person	Date/Time	Printed name

☐ Parent of Minor ☐ Court appointed guardian/conservator - include legal documentation

Wisconsin Authorizations:

Mail Copies to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Copies to: 715-389-0564
Email Copies to: himspec@marshfieldclinic.org

Michigan Authorizations:

Mail Form to: MMC-Dickinson, 1712 S. Stephenson St, Iron Mtn, MI 49801
ATTN: Health Information Management - ROI

Fax Form to: 906-221-6992
Email Form to: medicalrecords@marshfieldclinic.org

Marquette Center, 1414 W. Fair Ave, Suite 334
Marquette, MI 49855
ATTN: Health Information Management - ROI

Fax Form to: 906-225-3919

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Sharing of Information Authorization (Continued)

Patient Name:	MRN:	DOB:	Sex:

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  - research-related treatment
  - health plan enrollment or eligibility
  - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

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Marshfield Clinic
Health System

Patient Name:	MHN:	DOB:	Sex:

Consent Treatment of Minors in Parent/Legal Guardian Absence

To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

☐ I/We (parent's/legal guardian's name) ________________ authorize:

Appointee *(person authorized to consent)* North Cedar Academy Staff

Relationship to patient ________________ Appointee's phone number 715-532-0201

Appointee's address 1500 Port Arthur Road Ladysmith, WI 54848

to consent to - check (✓) all that apply:

☑ Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates when I cannot be reached

☑ Medical treatment, mental health treatment or dental care - including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) - at Marshfield Clinic Health System and affiliates

☑ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

for my child *(patient's name)* ________________

during the period (not to exceed maximum of 1 year):

☐ Date (month/day/year) / / ________ to / / ________

☑ For a maximum period of 1 year

☐ I/We (parent's/legal guardian's name) ________________ authorize:

my driving-age child *(patient's name)* ________________ to receive routine care,

unaccompanied during the period *(date - month/day/year)* / / ________ to / / ________

☐ I/We (parent's/legal guardian's name) ________________ authorize:

my child *(patient's name)* ________________ to attend physical/occupational therapy appointments

unaccompanied during the period *(date - month/day/year)* / / ________ to / / ________

☐ Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:

Home phone ________ Work phone ________ Cell phone ________

I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.

________________ ________________

Child's parent/legal guardian signature and Date & Time | Relationship to patient

________________ ________________

Child's parent/legal guardian address | Parent/Legal guardian phone number

Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org

 © 1999 Marshfield Clinic Health System *See next page for Telephone Consent documentation* Additional copy to patient

Patient Name:	MHN:	DOB:	Sex:

☐ Telephone consent *(or verbal consent to include those physically unable to sign)*

Today's date (month/day/year) ____/ /____ Time ________ Telephone ____- -________

Name of person authorizing ______________________ Relationship ____________

Reason for telephone consent ______________________________________

☐ Person authorized treatment/procedure

☐ Person **DID NOT** authorize treatment/procedure

______________________________ ______________________________

Witness signature and date & time PRINT witness name

______________________________ ______________________________

Second witness signature and date & time PRINT witness name

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Marshfield Clinic
Health System

Location: ______________________

Patient Name: ______________________

MRN: __________ DOB: __________ Sex: ______

Consent Treatment

General consent: I understand that I may have a health problem requiring evaluation, diagnosis, treatment and/or hospitalization. I voluntarily consent to necessary routine medical assessment, treatment, general diagnostic procedures, radiologic procedures, and/or hospital care ordered by my provider or his/her assistant. I recognize that my care is directed by physicians or other health care practitioners, some of who are not employed by, but rather serving as agents of the facility. I understand that the facility is not liable for any act or omission of the instructions given by such physicians while I am in the facility. For Inpatient services only, I understand that video-surveillance (e.g. video-taping, video-monitoring) may be used for the purposes of patient care, treatment, and/or safety. If I am pregnant, I agree that all the provisions of this Treatment Consent also apply to my newborn child/children for their care and treatment while in the hospital after birth.

Directions and information: Each patient has the right to consent to or refuse any proposed procedure or therapeutic treatment. I understand I should tell the provider or nurse if there is anything I do not want performed. The provider is responsible for explaining the nature of my condition and treatment and the other ways that this condition could be treated, if any. He/She is responsible for explaining significant risks involved with the treatment, if any.

No guarantee of care: I understand that the provision of health care services is not an exact science. I acknowledge that no guarantees have been made to me as to the results of examinations or treatments to be provided to me in the facility.

Personal valuables: I understand that the facility maintains a safe for storage of patient valuables during hospitalization. I agree that the facility does not assume liability for any loss or damage to valuables not deposited in this safe.

Health care education: I understand that some Marshfield Clinic Health System facilities participate in health care education or training programs and agree that, at times, I may receive health care services performed, or observed, by students or trainees under appropriate supervision. I understand that I have the right to decide who participates in providing care to me and that I may decline participation of students or trainees in delivery of care to me.

Medical records: I understand that, upon written request and with reasonable notice, I may review and receive a copy of my medical record, at my own expense, or have my records transferred to another health care provider. I understand that review of my records shall take place in the Medical Records department during regular business hours. I also understand that I may authorize other persons to review and receive a copy of my medical record by signing a Release of Information Authorization which identifies my name, the purpose of the disclosure, the type of information to be disclosed, the individual, agency, or organization to which the records are to be disclosed, and the time period during which disclosure is permitted. All releases of information must comply with the HIPAA policies and procedures.

Correspondence/Communication:

- **Consent to Contact:** I consent to receive communications from Marshfield Clinic Health System, its contractors and collection representatives on any phone number I provide or later acquire (cell or landline). I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. Contacts may be via live agent, voicemail, text message, auto dialer or other technology. I understand depending on my phone plan I may be charged for calls or text messages.I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.I understand that unencrypted text-messaging is not secure and I accept the risk of loss of privacy through text-messaging.
- **Use of Phone:** I agree Marshfield Clinic Health System, its affiliates and agents may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to Marshfield Clinic Health System for appointment and payment purposes.
- **Consent to Contact:** I consent to receive communications from Marshfield Clinic Health System, its contractors and collection representatives on any email address I provide or later acquire. I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. I understand my consent to receive such emails is not a condition of receiving healthcare services. I understand that unencrypted emailing is not secure and I accept the risk of loss of privacy through emailing.

CNS

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Additional copy to patient

Patient Name:	MRN:	DOB:	Sex:

Assignment and financial agreement: In consideration for services rendered by the hospital, I irrevocably assign my insurance benefits directly to Marshfield Clinic Health System (MCHS) and I agree that these benefits otherwise payable to me shall be paid directly to MCHS. I understand that I am financially responsible to the facility and I agree to pay the facility all such charges that are not paid by my insurance plan, Medicare, Medicaid, PPO, HMO or other coverage, in addition to co-payments and deductibles. If the account is referred for collection, I agree to pay the costs of collection, including actual attorney's fees.

Release of information for billing purposes: I agree that the facility and all health care providers participating in my treatment may release to, and receive from my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided to me.

Patient's certification/payment request under Title XVIII Social Security Act: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I assign payment of the unpaid charges for physician services to the physician or organization authorized to bill in connection with the services. If I am entitled to benefits under Title XVIII, I understand I am responsible for any health insurance deductible and coinsurance.

Notice of privacy practices acknowledgement: By signing this form, I acknowledge that the respective Marshfield Clinic Health System (MCHS) facility has provided me with a copy of the Notice of Privacy Practices. The Notice explains how my health information will be handled in various situations. If I have minor children (children under the age of 18) living with me, I also acknowledge by signing this form that I have received this Notice on their behalf. Marshfield Clinic Health System will make a good faith effort to obtain written acknowledgement of my receipt of the Notice upon my first date of service with this facility. If my first date of service at this facility was an emergency situation, Marshfield Clinic Health System will provide the Notice to me as soon as reasonably possible following the emergency situation.

Facility/Patient directory: In the event that I would be admitted to the hospital, I acknowledge that my name, location in the facility and general medical condition will be listed in the facility directory. The directory information will be provided to persons who ask for my information by my name. I understand that I must inform an employee if I object to this practice.

Patient rights and responsibility: I acknowledge that I have been notified of my patient rights and responsibilities, via written materials or posters in prominent locations. I am being informed that if a health care provider or employee is significantly exposed to my blood or body fluids, my blood may be tested for human immunodeficiency virus (HIV), the virus that causes AIDS. I agree to comply with all facility rules and regulations and with all patient responsibilities in the materials provided to me.

Follow-up responsibility: I understand that I may return home before all my medical problems are known or treated and that I may be given instructions to follow at home. I understand that it is my responsibility to arrange follow-up care and to follow through on any instructions provided.

Document acknowledgement: I certify that I have read and understand the foregoing Treatment Consent and all subsections, and that I am competent and authorized to execute it. I understand that I am not entitled to make any changes or alterations to this legal non-negotiable document. If I refuse to sign the document, service may be denied.

______________________	______________________	______________________
Patient signature (person authorized to consent for patient) and Date & Time	(Relationship to patient)	Printed name

______________________	______________________	______________________
Witness Signature	Date/Time	Printed name

See page 3 for Telephone Consent documentation

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Additional copy to patient

AUTHORIZATION FOR TREATMENT of a MINOR

Patient Name: ____ Date of Birth: ___/___/___

I hereby authorize ______North Cedar Academy Staff______ to bring the above named
(Name/Relationship to Patient)

individual to an OakLeaf Clinics, SC provider for care.

This authorization is in effect until: ___/___/___ Until graduating from NCA or unenrolling from NCA

Parent/Guardian Name: ____
(Please Print)

Parent/Guardian Signature: ____ Date: ___/___/___

FAMILY SHARED INFORMATION

Patient Name: ______________________________ **Date of Birth:** ___/___/___

I hereby consent that my healthcare information may be shared both verbally and by mail with the following individuals:

Name: North Cedar Academy Staff	Relationship: Staff
Telephone Number: 715-532-0201	

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Signature: ______________________________ **Date:** ___/___/___
(Parent)

WRITTEN ACKNOWLEDGEMENT OF RECEIPT

I, ____, acknowledge that I have received the written Notice
Print Name (Parent/Legal Guardian)

of Privacy Practices from Oakleaf Clinics, S.C. as a new patient and annually thereafter.

____ Date: ___/___/___
Patient or Personal Representative Signature

____
(Personal Representative, describe relationship to patient.)

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgement was unable to be obtained. Reason: ___________________________________

____

____

____

Employee Signature: _________________________________ Date: ___/___/___

OakLeaf Clinics, Inc.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- ✓ Get an electronic or paper copy of your medical record.
  - o You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  - o We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- ✓ Ask us to correct your medical record.
  - o You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - o We may say "no" to your request, but we'll tell you why in writing within 60 days.
- ✓ Request confidential communications.
  - o You can ask us to contact you in a specific way (for example, home or office phone) or mail to a different address.
  - o We will say "yes" to all reasonable requests.
- ✓ Ask us to limit what we use or share.
  - o You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - o We are not required to agree to your request, and we may say "no" if it would affect your care.
  - o If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - o We will say "yes" unless a law requires us to share that information.
- ✓ Get a list of whom we've shared information.
  - o You can ask for a list (accounting) of the times we've shared your health information for six years before the date you asked, who we shared it with, and why.
  - o We will include all the disclosures except those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but charge a reasonable, cost-based fee if you ask for another within 12 months.
- ✓ Get a copy of this privacy notice.
  - o You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- ✓ Choose someone to act for you.
  - o If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - o We will ensure the person has the authority and can act for you before we act.
- ✓ File a complaint if you feel your rights are violated.
  - o You can complain if you feel we have violated your rights by contacting us.
  - o You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  - o We will not retaliate against you for filing a complaint.

YOUR CHOICES

You can tell us your choices about what we share for certain health information. Talk to us if you have a clear preference for how we share your information in the situations described below. Tell us what you want us to do, and we will follow your instructions.

- ✓ In these cases, you have both the right and choice to tell us to:
  - o Share information with your family, close friends, or others involved in your care.
  - o Share information in a disaster relief situation.
  - o Include your information in a hospital directory.
- ✓ If you cannot tell us your preference, for example, if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information to lessen a serious or imminent threat to your health or safety.
- ✓ In these cases, we never share your information unless you give us permission:
  - o Marketing purposes.
  - o Sale of your information
  - o Most sharing of psychotherapy notes
- ✓ In the case of fundraising:
  - o We may contact you for fundraising efforts, but you can tell us not to contact you again.

OTHER USES AND DISCLOSURES

Who do we typically use or share your health information? We typically use or share your health information in the following ways.

- ✓ Treat you. We can use your health information and share it with other professionals treating you.
  - o Example: A doctor treating you for an injury asks another doctor about your health.
- ✓ Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  - o Example: We use health information about you to manage your treatment and services.
- ✓ Bill services. We can use and share health information to bill and get payment from health plans or other entities.
  - o Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before sharing your information for these purposes. For more information, see www.hss.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- ✓ Help with public health and safety issues. We can share health information about you for certain situations, such as:
  - o Preventing disease
  - o Helping with product recalls
  - o Reporting adverse reactions to medications
  - o Reported suspected abuse, neglect, or domestic violence
  - o Preventing or reducing a serious threat to anyone's health and safety
- ✓ Do research
  - o We can use or share your information for research
- ✓ Comply with the law
  - o We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.
- ✓ Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

- ✓ Work with a medical examiner or funeral director.
  - When an individual dies, we can share health information with a coroner, medical examiner, or funeral director.
- ✓ Address workers' compensation, law enforcement, and other government requests
  - We can use or share health information about you for:
    - Workers compensation claims
    - For law enforcement purposes
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- ✓ Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order or a subpoena.

OUR RESPONSIBILITIES

- ✓ We are required by law to maintain the privacy and security of your protected health information.
- ✓ We will let you know promptly if a breach may have compromised your information's privacy and security.
- ✓ We must follow the duties and privacy practices described in this notice and give you a copy.
- ✓ We will not use or share information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind anytime. Let us know in writing if you change your mind.

For more information, see www.hhs.gove/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, which will apply to all information we have about you. The new notice will be available upon request in our office and on our website.

Effective Date: January 1, 2015
Revised: 03/26/19; 05/02/2019; 2/8/2021, 6/23/2022, 12/13/2023

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND AUTHORIZED REPRESENTATIVE AGREEMENT

In return for the services I receive and/or have received from OakLeaf Clinics Inc. ("**Provider**"), I agree to:

1. **Assignment of Benefits.** As a participant, beneficiary, or insured, I hereby irrevocably assign and transfer to Provider for application only to my medical bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including but not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided to me by Provider (collectively, "**My Coverage**"). These assigned and transferred rights include, but are not limited to:

   a) The right to receive payment for any medical bills incurred as a result of services provided by Provider;
   b) The right to obtain information about My Coverage, including but not limited to information about plan features and funding;
   c) The right to appeal any adverse benefit determination or other denial;
   d) The right to bring fiduciary duty claims or seek declaratory or injunctive relief or penalties on my behalf;
   e) The right to submit any dispute in my name to binding arbitration.

   I permit a copy of this Agreement to be used in place of the original for the purpose of obtaining payment under My Coverage. To the extent my rights are alleged to be non-assignable, and in addition to my appointment of an authorized representative below, I retain the right to payment but direct and authorize My Coverage to send any reimbursement check, payable to me, directly to Provider. I understand that despite any benefits ultimately received by Provider as a result of this assignment, I am financially responsible to Provider for any charges not paid, in whole or in part, by My Coverage, including but not limited to co-payments, deductibles, co-insurance, and non-covered services under My Coverage.

   Attention Plan Administrators and Insurance Carriers: This is a direct assignment of my rights and benefits under My Coverage which is your plan or policy. If applicable under My Coverage, I hereby request your consent to the form and content of this Agreement, and the resulting legal rights assigned and transferred to Provider. Your failure to withhold or deny your approval on reasonable grounds within 72 hours of receipt of this request shall constitute your approval of this Agreement.

2. **Limited Power of Attorney and Appointment of Authorized Representative**. In the event My Coverage does not accept my assignment, or My Coverage prohibits my assignment of certain or all rights or benefits, or my assignment is otherwise challenged or deemed invalid, I execute this limited power of attorney and irrevocably designate, authorize, and appoint Provider and Provider's attorney (collectively, "**My Representative**") as my agent, personal and authorized representative, and attorney for the limited purpose of collecting payment for Provider's services directly against My Coverage, in my name, including but not limited to administrative and other appeals and arbitration/litigation. I specifically authorize My Representative to file directly against My Coverage in my name or in Provider's name as a medical provider rendering services to me, and designate My Representative as my personal and authorized representative and attorney in fact.

   I further grant a limited power of attorney to Provider as my medical provider to receive and collect directly from My Coverage any and all money due Provider for services rendered to me, and instruct My Coverage to pay Provider directly any monies due Provider for medical services that Provider provided to me. I further authorize My Representative to receive from My Coverage, immediately upon request, all information regarding payment(s) made by My Coverage on my claim(s), including date(s) of payment(s) and balance(s) of benefits remaining. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against My Coverage will be paid to Provider when acting as My Representative.

   This limited power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and the remedies available under applicable statutory and regulatory guidelines for the medical care services that Provider provided to me. I hereby confirm and ratify all actions taken by My Representative pursuant to the authority granted in this Agreement.

3. **Cooperation**. I agree to cooperate with Provider to pursue all available remedies, benefits, and payment. I agree to fulfill any reasonable request from Provider such as signing correspondence or obtaining information about My Coverage from my employer or insurer. I agree that no guarantees have been made to me as to the results of examinations or treatments provided to me by Provider.

4. **Insurance, Health Benefits Coverage, and/or Medical Assistance**. **It is my responsibility to provide Provider with current and accurate My Coverage and/or medical assistance program(s) information at the time of service.** I certify that the information given by me in applying for payment under My Coverage and/or medical assistance program(s) is correct. I authorize Provider to release any information about me which is properly needed for processing and paying My Coverage and/or medical assistance program(s) claims.

5. **Responsibility for Payment**. I understand that am responsible for all amounts not otherwise paid, in whole or in part, by My Coverage, including but not limited to **co-payments, deductibles, co-insurance,** and **non-covered services** under My

Coverage. I agree to pay for all charges that are due because of my care and treatment by Provider in accordance with Provider's regular charge-master rates and terms. I agree to pay any applicable co-payments at the time of service. I also understand that I am responsible for paying Provider in full for services My Coverage will not cover due to non-payment of any premiums required under My Coverage. I understand that although Provider may file claims with My Coverage as a courtesy to me, I am ultimately responsible to pay for the services received.

6. **No Show and Cancellation Policy.** I understand that Provider requires 24-hour notice if I am unable to keep a previously scheduled appointment. In the event I do not provide 24 hour notice or do not show up for my appointment, Provider reserves the right to charge a $25 fee to your account.

7. **Returned Checks.** I understand that if any check payment is returned due to NSF (non-sufficient funds) or a cancelled check, I will be charged a $35 NSF fee. This fee, as well as the account balance, is due upon receipt. Provider will reserve the right to only accept payment in the future for my account with cash, credit or debit cards.

8. **Payment Plan Options.** I understand that if I have an outstanding balance as the result of Deductibles, Co-Insurance, or self-pay, I have the option to work with Provider to set up a mutually agreeable payment plan approved by Provider. Provider will not waive, fail to collect, or discount co-payments, co-insurance, deductibles or other patient financial responsibility in accordance with State and Federal law, as well as participating agreements with payers. I understand that future services may be denied if my account is not current or I have failed to make payment arrangements on my account. I also understand that I may be asked for payment for services in advance. Additional payment options may be available through Provider's Payment Assistance Program.

9. **Self-Pay Accounts.** Self-pay accounts are patients without insurance coverage, patients unable to present a valid member identification card from your health insurance carrier or if Provider is not able to verify active health insurance coverage. Self-pay patients may be eligible for a 15% discount. Payment is expected in full at the time of service. Any self-pay balances remaining will be my financial responsibility. Failure to pay my self-pay balance may result in removal of discount.

   I agree to pay all amounts due within the time period described in my billing statement(s). It is my responsibility to contact Provider's billing department to make payment arrangements for all balances not paid in full within the time period described in my billing statement(s). I authorize Provider to transmit billing statements to me electronically. In the event I have not made arrangements for payment and my account is placed with an attorney or collection agency, I am responsible for collection fees, attorneys' fees and court costs. I hereby provide Provider and its representatives and business associates (including third party debt

collectors) my permission to contact me for any purpose associated with my account, including via wireless telephone numbers. I understand that this may include the use of automated dialing equipment, prerecorded voice, or text messages.

I certify that I have read this Agreement, had the opportunity to ask questions about it, and understand its contents. If the patient is a minor, I attest that he/she is a beneficiary under My Coverage and that I sign as a parent/guardian and as the person financially responsible for payment for any medical bills. I agree that this Agreement constitutes the sole and entire agreement between me and Provider regarding the subject matter of this Agreement, and it replaces all prior understandings or agreements regarding such subject matter.

_______________________________ _______________________
Signature of Patient or Parent/Guardian Date

_______________________________ _______________________
Print Patient's Name Date

____
Provider Witness to the Above Signature

Rusk County Public Health Department
311 Miner Ave. E., Suite C220
Tel: (715) 532-2299 Ladysmith, WI 54848 Fax: (715) 532-2217
Web: https://ruskcounty.org/publichealth
(For deaf and/or hard of hearing, please call us through Wisconsin Relay 711)

Dear Parent or Guardian,

This letter is to inform you of the required vaccinations needed for your child to attend school at North Cedar Academy in Ladysmith, WI. The minimum required vaccinations under the Wisconsin Student Immunization law are as follows.

- 1 dose of Tdap (Tetanus, diphtheria and acellular pertussis)
- 4 doses of Polio
- 3 doses of Hepatitis B
- 2 doses of Meningococcal ACWY
- 2 doses of MMR (Measles, Mumps, Rubella)
- 2 doses of Varicella (History of chickenpox illness must be verified by a qualified medical provider. Self or parent/guardian report of past chickenpox illness does not meet the requirement.)

If your child has any immunization records please send them to North Cedar Academy for vaccines to be updated in the Wisconsin Immunization Registry and for staff to refer to as needed. If you wish to wave the required vaccinations for your child you can do so by filling out form F-04020L, Student Immunization Record – step 4, and returning it to the school.

This form is valid for the school year of 2024/2025. By signing this form you agree to either (select one option below)

____ have your child vaccinated with all minimum required vaccinations by the Rusk County Public Health Department or

____ have the vaccinations waived along with the required form F-04020L, Student Immunization Record.

There are other vaccinations that are highly recommended, but **NOT** required for your child to attend school in the state of Wisconsin. If you wish to have your child receive any of the following immunizations please check each box below.

____ Flu (Influenza)
____ HPV (Human Papillomavirus)
____ Meningococcal B
____ Hepatitis A

Student Name ______________________________ Date of Birth ____________

Parent or Guardian Signature ______________________________ Date ____________

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2020)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 PERSONAL DATA PLEASE PRINT

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES _____ Year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

Step 3 REQUIREMENTS

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 COMPLIANCE DATA

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

Or

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has **NOT** received **ALL** the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: **Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.**

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ For health reasons this student should not receive the following immunizations ______________________

SIGNATURE - Physician ______________________ Date Signed ______________________

☐ For **religious reasons**, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ For **personal conviction reasons**, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

Step 5 SIGNATURE

This form is complete and accurate to the best of my knowledge. Check one: (I do ☐ I do not ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student ______________________ **Date Signed** ______________________

Wisconsin Immunization Registry
Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

CLIENT ID | **CHART NUMBER**

Patient's Name (Last, First, Middle) | Date of Birth (mm/dd/yyyy)

Social Security Number | Gender ☐ Male ☐ Female | Ethnicity (Check One) ☐ Hispanic ☐ Non-Hispanic

Race (Check One)
☐ American Indian or Alaska Native ☐ Other ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Black or African American

Mother's (if married, patient's) Maiden Name (Last, First, Middle)

Name of Physician (First Last) | County Primary Address | Country of Birth

Name of Parent or Guardian Responsible for Patient (Last, First, Middle) | Relationship to Patient

Address | P.O. Box | Email address (if applicable)

City | State | Zip Code | Telephone Number ( ) | Extension

Is reminder/recall contact allowed? ☐ Yes ☐ No

Would you like reminder/recall sent to you? ☐ Yes ☐ No

Eligibility Status
(Check all that apply)
This section must be completed.
☐ Medicare ☐ Medicaid Eligible ☐ Insured, Vaccines Covered
☐ Badger Care ☐ Native American or Alaskan Native ☐ No Health Insurance
☐ Insured, Vaccines Not Covered

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here if you do not give your permission ☐

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf | Date Signed

X