Dear Parent/Guardian,

Curtis V. Cooper Primary Healthcare, Inc. has joined in collaboration with Savannah-Chatham County Public Schools to improve health care accessibility for your child.

Your child's school has been selected to participate in a School Based Initiative and your child may receive certain health care services at no cost to you. Reimbursement from third party payers will be billed accordingly. Health Teams consisting of physicians, dentists, advanced registered nurse practitioners, registered nurses, license practical nurses, and licensed social workers will provide the traditional school health services. These traditional services are routinely provided and include rendering first aid, medication administration and provision of classroom lectures and activities as well as counseling/behavioral health. By enrolling your child into the School Based Initiative, he/she will also be eligible to receive physical examinations, blood and urine tests, oral health services, and vaccinations through access to the Mobile Healthcare Van on designated days. A licensed physician will provide medical oversight for the staff.

To enroll your child, a completed general consent form is required. The consent form enables you to receive services at all Curtis V. Cooper Primary Healthcare locations. All students are eligible. After the form is received, designated health care services are provided directly at your child's school. Please contact your school administrator with any questions you may have.

It is our goal to contribute to the physical, mental, and social well-being of each student.

Sincerely,

Albert B. Grandy, Jr.
Chief Executive Officer

Fariborz A. Zaer. M. D.
Medical Director

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT

1. I, the undersigned or legal guardian, grant permission as indicated below to undergo all necessary tests, treatments, and other procedures or studies required for the diagnosis by the medical staff and other employees of Curtis V. Cooper Primary Healthcare, Inc.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Curtis V. Cooper Primary Healthcare, Inc.

3. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Curtis V. Cooper Primary Healthcare, Inc. by law, rules, regulations, or by consent.

4. I consent to the release of medical and financial information for auditing purposes.

5. I hereby authorize payment to Curtis V. Cooper Primary Healthcare, Inc. of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Curtis V. Cooper Primary Healthcare, Inc. for payment.

6. MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

7. BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY CURTIS V. COOPER PRIMARY HEALTHCARE, INC. OF ANY CHANGES TO MY INSURANCE, INCOME, OR CONTACT INFORMATION.

Name of Patient (PLEASE PRINT)	CVCPHC Representative (PLEASE PRINT)
Signature of Patient or Legal Guardian	CVCPHC Representative's Signature

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

In-House Referral

Referring School (Indicate by checking the appropriate school)
○ East Broad Elementary School
○ Shuman Elementary School
○ Building Bridges School Middle
○ Wings Elementary Alternative School

Referral Source (Indicate name below)
○ Teacher
○ Parent
○ Support Staff (Indicate title of support staff below) _____

Patient Information	
Name:	Date of Birth:
Grade: K4	
Reason for Referral:	
Was a parental consent form obtained?	
○ Yes	○ No
Internal Use Only	
Was an appointment given?	
○ Yes	○ No