

Treatment Consent and Billing Authorization

Student Name: _____ Date of Birth: _____

I, Parent/Guardian, consent to allow my child's school district and/or the Tulare County Office of Education (TCOE) to provide mental and behavioral health services aimed at enhancing student well-being, skill development, and fostering social support. My child's school district and TCOE are committed to supporting the well-being of all students by providing mental and behavioral health services. Support may include counseling, skill-building sessions, group interventions, and other related services designed to help students navigate personal, social, and emotional challenges.

I consent to allow my child's school district and/or the Tulare County Office of Education (TCOE) to provide these services via telehealth when deemed appropriate by the qualified healthcare provider. Telehealth services involve the delivery of mental health and behavioral health services using electronic communications between a provider in one location, and the child in another location by use of audio/video or phone to complete the service. All information discussed via a telehealth appointment will be held to the same privacy standards as that of an in-person appointment. I also understand that by me or my child using a personal device for telehealth services, my child's school district and/or TCOE does not have control over or the authority to protect my child's health information that may be stored within the device in the event that the device is lost, stolen, or given away.

I consent to allow my child's school district and/or the Tulare County Office of Education (TCOE) to bill my child's health insurance plan for services provided to my child under the Children and Youth Behavioral Health Initiative (CYBHI). I understand that I will not be personally billed for any services my child receives at school. I understand that if my child is or may become eligible for services under CYBHI, I authorize my child's school district and/or TCOE to release student information for the limited purposes of billing health insurance plans and to access health insurance for applicable services. This will not affect any insurance benefits I currently have or may receive. I understand that this information will be used solely for billing purposes and remains confidential under the Family Educational Rights and Privacy Act (FERPA) and/or the Health Insurance Portability and Accountability Act (HIPAA) where applicable.

I acknowledge that my consent applies solely to the services offered by the LEA, its designated providers and/or affiliated provider. I am aware that I can change my decision at any time and opt out of receiving services from the LEA, its designated providers and/or affiliated provider. If I choose to do so, I will inform the LEA in writing by sending a letter to your child's school district or school site. I understand that this consent form remains effective until the LEA receives a written revocation from me.

I am the parent or legal guardian that is legally authorized to make health care decisions or non-emergency medical decisions on behalf of the dependent named in this document. This authorization and consent shall be effective upon my signing and shall be effective, as to the dependent through the date the dependent graduates from the school district in which the dependent is currently enrolled.

By signing below, I acknowledge that I have been informed of the availability of these services and consent to my child's participation as needed. I understand that these services are provided by qualified professionals and are intended to support my child's overall well-being. I understand that if any additional, more intensive services are required, I will be informed and given the opportunity to provide my consent for these higher-level services.

Role (check one): ☐ Student (12+) ☐ Parent/Guardian (Print Name) _____

Consent to Treatment:

Signature: _____ Date: _____

Consent to Billing:

Signature: _____ Date: _____

Insurance Information

Student Name: _____ Student Date of Birth: _____

Insurance Type:

☐ Medi-Cal ☐ Anthem Blue Cross ☐ Health Net ☐ Blue Shield ☐ United Healthcare

☐ Other: _____

Insurance Member ID #: _____