OneSource Mobile Healthcare
Mobile Vision Services
Consent and Release Form

Dear Parent/Guardian;

OneSource Mobile Healthcare offers eye exams and glasses to kids at no cost. OneSource Mobile Healthcare will be providing its mobile vision eye care at your child's school to provide eye exams and glasses to children who need them. If you would like to give your child permission to participate in this program, please complete and return this form. Return the completed form to the school nurse. There is no cost for your child to participate in the program.

However if your child is covered by Medicaid and/or has private health insurance coverages, then your benefits will be used to cover the services offered to your child. You will not be billed for services provided by OneSource Mobile Healthcare, PLLC.

OneSource Mobile Healthcare will occasionally collect images and/or academic information about children in order to publicize and evaluate its programs. You agree that your child may be photographed, filmed and/or recorded in any format (collectively called "Photographs") and that OneSoure Mobile Healthcare will own and may use such recordings in any format without compensation to your child or your child's parents or guardians. You agree that One Source Mobile Healthcare may collect your child's academic, behavioral, attendance, and demographic data (collectively called "Data") from your school or youth service organization. You agree that you are waiving any and all claims against your school and OneSource Mobile Healthcare that may arise from your participation in the program or use of the Photographs or the Data.

YES. I agree to allow my child to participate in the OneSource Mobile Healthcare Mobile Vision Clinic Program, described above.

PLEASE PRINT OR TYPE

Child's First Name:		Child's Last Name
Child's Date of Birth: Month / Day / Year		Child's Gender (please check one): ☐ MALE ☐ FEMALE
Parent/Guardian First Name:		Parent/Guardian Last Name

CONTACT INFORMATION:

Street Address:	Apt/Unit:	City	State	ZipCode
Phone Number:	Emergency Phone Number:	Email:		

SCHOOL INFORMATION:

Name of School:	Name of Teacher:
Grade:	Classroom:

INSURANCE INFORMATION:

☐ Child Has Medicaid

Provider:	I.D. Number:

☐ Child Has Private Insurance

Provider:	I.D. Number:

☐ Child Is Uninsured

By signing this form, I agree to allow my child to receive vision care services through OneSource Healthcare's Mobile Vision Clinic. I acknowledge that I have the right to refuse any services provided by OneSource Mobile Healthcare but am choosing voluntarily for my child to receive vision services. I understand that receiving vision services through OneSource Mobile Healthcare's Mobile Vision Clinic will disqualify me from accessing non-mobile services.
I also authorize the release of any medical or related information required for the provider to submit a claim and receive payment form Medicaid or other insurance plans, where applicable, for vision services provided to my child. I agree that I am waiving any and all claims against the school where my child is a student that may arise from my child's participation in the program. My signature shows that I have read and understood this voluntary Consent and Release and agree to all its provisions.

Parent/Guardian Signature: _____ Date: _____

7620 E McKellips Rd, Ste 4-225, Scottsdale, AZ 85257
Phone: (888)495-4489 Fax: 602-325-0169

onesourcemobilehc.com
info @onesourcemobilehc.com