



Preparing every student to thrive in a global society.

East Side High Union School District

Consent for Billing Health

Insurance

Consent for Participation in School-Based Wellness Services

School Site: _____

Student Name: _____

Consent for School-Based Wellness Services

We are seeking your consent for your child to receive school-based wellness services, designed to support their emotional, social, and mental well-being as needed. These services may include: check-ins, wellness center walk-in sessions, practicing stress management tools, learning mindfulness activities, or reviewing resources to support academic goals - all facilitated by trained professionals. *If your student engages in such services, you may be notified by your school site.* These programs provide a supportive environment to foster personal growth and address challenges your child may face. Please note your consent is voluntary, and you may revoke it at any time by notifying the school in writing. To acknowledge your understanding and provide your consent, please check the box below.

☐ I have reviewed this message and consent to school-based wellness services.

Consent for Billing Health Insurance

Per the Children and Youth Behavioral Health Initiative (CYBHI), schools are now able to seek reimbursement for commercial health plans for school-based wellness services. These services do not in any way impact your existing benefits, and there are no co-payments of any kind.

Billing your insurance allows us to sustain and expand these essential services at no additional cost to your family. Please be assured that your personal information will be handled securely, and this consent is voluntary. You may revoke your consent at any time by notifying the school in writing. Your student will have access to our school-based wellness services regardless of whether you give us consent to bill. To acknowledge your understanding and provide your consent, please check the box below. Thank you for your support as we participate in CYBHI to expand access to wellness services for all students.

☐ I have reviewed this message and I give consent to my school district to bill my insurance. I understand that this does not in any way impact existing benefits, and there are no co-payments of any kind.



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There are NO CHARGES to you for this billing.

By giving consent, you are acknowledging that:

1. You have been fully informed of the district's intent to determine eligibility and bill insurance (at no cost to you) for wellness services.
2. You understand that the granting of consent is voluntary on your part and may be revoked at any time.
3. If you revoke consent, the revocation is not retroactive, which means that it does not negate any activity that has already taken place.

Parent/guardian signature

Date

Student name (print)

Date of birth

I. Primary Insurance

Insurance Provider: _____

Policy Number: _____ Group Number: _____

Phone Number: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Student: _____

II. Secondary Insurance

Insurance Provider: _____

Policy Number: _____ Group Number: _____

Phone Number: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Student: _____

To learn more about the Children and Youth Behavioral Health Initiative and how this vital funding stream can support your students school maintain support programming please click on the following link [CYBHI Info for Caregivers](#)