OMAHA PUBLIC SCHOOLS
School Based Health Services Enrollment and Consent Form
Enrollment is OPTIONAL

2020-21

Student Information

Student Last Name (legal): Student Number:
First Name (legal): Student Middle Name (full):
Home Address: City: Zip:
Gender: M / F Birth Date (mm/dd/yyyy): / /
Grade: Name of School Attending:

Parent/Guardian

Parent Last Name (legal): Parent First Name (legal):
Parent Middle Name (full): Parent Birthdate (mm/dd/yyyy):
Parent/Legal Guardian: ☐ Yes ☐ No Relationship to Student:
Home Phone: Work Phone: Cell Phone:
Email: May we text your cell phone number? ☐ Yes ☐ No

Second Parent/Guardian

Parent Last Name (legal): Parent First Name (legal):
Parent Middle Name (full): Parent Birthdate (mm/dd/yyyy):
Parent/Legal Guardian: ☐ Yes ☐ No Relationship to Student:
Home Phone: Work Phone: Cell Phone:
Email: May we text your cell phone number? ☐ Yes ☐ No

School Based Health Services

School-based health services (SBHS) will be available at your child's school or a nearby school. These services will be provided by OneWorld Community Health Centers (OWCHC), Charles Drew Health Center (CDHC), UNMC, Creighton University (Creighton), Children's Hospital & Medical Center (Children's) or other contracted service providers. The school nurse will coordinate care with the school-based health service providers once your child is enrolled.

SBHS will coordinate care with your child's primary care provider, dentist, optometrist/ophthalmologist and/or behavioral health provider. If you have private health insurance or Medicaid, SBHS providers will bill your insurance carrier for services provided. If you do not have health insurance, the SBHS provider will assist families with enrollment in Medicaid, if eligible.

School Based Health Centers

School Based Health Centers (SBHC): ability to screen health status, test for, diagnose and treat common conditions, e.g., sore throats, minor injuries, headaches, immunizations, ear infections, and diseases such as hepatitis, tuberculosis and sexually transmitted diseases. Nebraska state law allows students to choose whether a parent will be notified of a student's care related to sexually transmitted infections. The SBHC will not provide emergency services. The SBHC may provide behavioral and/or psychiatric services and may also include the use of telehealth technology.

To enroll your child in SBHC and allow OPS to give SBHC staff confidential information for diagnosis and treatment, a signed enrollment and consent form must be on file with OPS and the SBHC provider. The SBHC staff will attempt to contact you regarding your child's visit and services provided.

By signing this enrollment and consent form, you consent to the following:

- ***I authorize*** OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child with school-based health services, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS staff, including the school nurse, and United Way of the Midlands on behalf of OPS, to release the following student information to the School Based Health Centers identified above so that they can provide services and conduct program evaluation: family and emergency contact information, state student number, attendance and disciplinary records, schedule, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and information regarding any health condition, such as seizures, allergies, concussions or asthma.

Dental Services

Dental Services: Where required by law, OPS provides dental screening services conducted by parties contracting with OPS. Services may include oral health education, screenings, fluoride varnish application, preventative care/cleaning, restorative/corrective care, and use of telehealth technology. OPS may provide dental screenings in addition to those required by law. By signing this consent form, you consent to the following:

- ***I authorize*** UNMC, OWCHC, CDHC, Creighton and/or other contracted provider to examine and treat my child with dental screenings and follow-up treatment, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS staff, including the school nurse, to release the following student information to the identified dental service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of dental screenings.

Vision Services

Vision Services: Where required by law, OPS provides vision screening services conducted by parties contracting with OPS. OPS may provide vision screening services in addition to those required by law. Services may include screening, examination, treatment and/or corrections such as eyeglasses, and may include telehealth. By signing this consent form, you consent the following:

- ***I authorize*** Children's and/or other contracted provider to examine and treat my child with vision screenings (where OPS is not required by law to provide the screenings) and exams, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS including the school nurse, to release the following student information to the identified vision service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of vision screenings and exams.

This authorization expires when my child leaves OPS or graduates. I understand that I may revoke this authorization at any time by submitting a letter to the Omaha Public Schools, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024 or by checking the box to revoke below.

School Based Health Centers	☐ No	☐ Yes	I authorize OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child as described above. I further authorize OPS to release information as described above.
Dental Services	☐ No	☐ Yes	I authorize my child to receive dental services through UNMC, OWCHC, CDHC and/or Creighton. I further authorize OPS to release information as described above.
Vision Services	☐ No	☐ Yes	I authorize my child to receive vision services through Children's and/or other contracted service providers as described above. I further authorize OPS to release information as described above.

Parent/Guardian Signature Relationship to Child Date

Omaha Public Schools does not discriminate on the basis of race, color, national origin, religion, sex (including pregnancy), marital status, sexual orientation, disability, age, genetic information, gender identity, gender expression, citizenship status, veteran status, political affiliation or economic status in its programs, activities and employment and provides equal access to the Boy Scouts and other designated youth groups. The following individual has been designated to accept allegations regarding non-discrimination policies: Superintendent of Schools, 3215 Cuming Street, Omaha, NE 68131 (531-299-9822). The following individual has been designated to handle inquiries regarding the non-discrimination policies: Director for the Office of Equity and Diversity, 3215 Cuming St, Omaha, NE 68131 (531-299-9765).

Office Use Only: ☐ Verified ☐ Programs ☐ Sections Initials

OMAHA Public Schools

ESCUELAS PÚBLICAS DE OMAHA
Formulario de Inscripción y Consentimiento del Servicios de Salud basado en la Escuela
La Inscripción es OPCIONAL

2020-21

Información del Estudiante		
Apellido del Estudiante (legal):		Número de Estudiante:
Primer Nombre del Estudiante (legal):	Segundo Nombre del Estudiante (completo):	
Dirección de la casa:	Ciudad:	Código Postal:
Sexo:	Fecha de Nacimiento (mes/día/año):	
Grado:	Nombre de la Escuela que Asiste:	
Padre/Madre/Tutor		
Apellido del Padre/Madre/Tutor (legal):	Primer Nombre (legal):	
Segundo Nombre (completo):	Fecha de Nacimiento (mes/día/año):	
Padre/Madre/Tutor Legal: ☐ Sí ☐ No	Relación con el Estudiante:	
Teléfono de Casa:	Teléfono del Trabajo:	Teléfono Celular:
Correo electrónico:	¿Podemos enviarle mensajes de texto a su número? ☐ Sí ☐ No	
Padre/Madre/Tutor		
Apellido del Padre/Madre/Tutor (legal):	Primer Nombre (legal):	
Segundo Nombre (completo):	Fecha de Nacimiento (mes/día/año):	
Padre/Madre/Tutor Legal: ☐ Sí ☐ No	Relación con el Estudiante:	
Teléfono de Casa:	Teléfono del Trabajo:	Teléfono Celular:
Correo electrónico:	¿Podemos enviarle mensajes de texto a su número? ☐ Sí ☐ No	

Servicios de Salud basados en la Escuela

Los servicios de salud basados en la escuela (siglas en inglés SBHS) estarán disponibles en la escuela de su hijo o en una escuela cercana. Estos servicios serán provistos por los Centros de Salud Comunitarios OneWorld (siglas en inglés OWCHC), el Centro de Salud Charles Drew (siglas en inglés CDHC), UNMC, Universidad Creighton (Creighton), Hospital de Niños & Centro Médico (Children's) u otros proveedores de servicios contratados. La enfermera de la escuela coordinara el cuidado con los proveedores de servicio de salud ya que su hijo sea inscrito.

SBHS coordinara el cuidado con el proveedor principal del cuidado de su hijo, dentista, optometrista/oftalmólogo y/o proveedor de salud de conducta. Si usted tiene un seguro de médico privado o Medicaid, los proveedores de SBHS enviaran la factura a su seguro por los servicios provistos. Si usted no tiene seguro médico, SBHS ayudara a las familias con la inscripción a Medicaid, si es elegible.

Centros de Salud basados en la Escuela

Centros de Salud basados en la Escuela (siglas en inglés SBHC): tienen la habilidad de evaluar el estado de salud, examinar, diagnosticar y tratar condiciones comunes, ej. Dolores de garganta, lesiones menores, dolores de cabeza, vacunas, infecciones de oídos, y enfermedades tales como el hepatitis, tuberculosis y enfermedades transmitidas sexualmente. La ley del estado de Nebraska permite a los estudiantes a escoger ya sea que un padre sea notificado del cuidado relacionado a infecciones transmitidas sexualmente. El SBHC no proveerá servicios de emergencia. El SBHC podrá proveer servicios de conducta y psiquiátricos y puede también incluir el uso de tecnología de tele salud.

Para inscribir a su hijo en SBHC y permitir a OPS a proveer información confidencial al personal de SBHC para el diagnóstico y tratamiento debemos tener en nuestros expedientes de OPS y del proveedor SBHC un formulario de inscripción y consentimiento firmado. El personal de SBHC tratara de contactarlo a usted referente a la visita y los servicios provistos a su estudiante. Al firmar este formulario de inscripción y consentimiento, usted da el consentimiento a lo siguiente:

- ***Yo autorizo*** al Centro de Salud Comunitario OneWorld y/o al Centro de Salud Charles Drew, para examinar y tratar a mi hijo con los servicios de salud basados en la escuela y entiendo que no se ha hecho ninguna garantía de los resultados de tales exámenes y tratamientos.
- ***Yo autorizo*** al personal de OPS, incluyendo a la enfermera escolar, el "United Way of the Midlands" de parte de OPS, a liberar la siguiente información del estudiante al SBHC identificados anteriormente para que provean servicios y lleven a cabo una evaluación del programa: Información de contactos de familia y de emergencia, número del estado del estudiante, asistencia y récords de disciplina, horarios, historial de vacunas, resultados de evaluaciones de salud tales como de audición y visión, evaluaciones psicológicas, récords de educación especial (IEP-MDT), Sección 504 del Plan de Adaptación, e información concerniente a la condición de salud tal como convulsiones, alergias, conmoción cerebral y asma.

Servicios Dentales

Servicios Dentales: Donde sea requerido por la ley, OPS provee servicios de evaluación dentales conducidos por contratistas por OPS. Los servicios pueden incluir educación de salud oral, evaluaciones, aplicación de barniz de fluoruro, limpieza/cuidado preventivo, cuidado restaurativo/correctivo, y uso de tecnología de tele salud. OPS puede proveer evaluación dental junto con lo requerido por la ley. Al firmar este formulario de inscripción y consentimiento, usted da consentimiento a lo siguiente:

- ***Yo autorizo*** a UNMC, OWCHC, CDHC, Creighton, y/u otros proveedores contratistas para evaluar y tratar a mi hijo con exámenes dentales y evaluaciones de tratamiento de continuación y entiendo que no se ha hecho ninguna garantía de los resultados de tal examinación y tratamiento.
- ***Yo autorizo*** al personal de OPS, incluyendo la enfermera escolar, para liberar la siguiente información estudiantil a los proveedores de servicio dentales identificados y para conducir la evaluación del programa, número de estudiante estatal y resultados de evaluaciones dentales.

Servicio de Visión

Servicios de Visión: Donde sea requerido por la ley, OPS provee servicios de evaluación de la visión conducidos por partes contratados con OPS. OPS puede proveer servicios de evaluación de visión adjunto a aquellos requeridos por la ley. Los servicios pueden incluir evaluaciones, examinaciones, tratamientos y/o correcciones tales como lentes y puede incluir tele salud. Al firmar este formulario, usted da el consentimiento a lo siguiente:

- ***Yo autorizo*** a Children's y/u otros proveedores contratados para examinar y tratar mi hijo con evaluaciones de visión (donde OPS no está requerido por ley a proveer las evaluaciones) y exámenes, y entiendo que no se ha hecho ninguna garantía de los resultados de tal examinación y tratamientos.
- ***Yo autorizo*** al personal de OPS, incluyendo la enfermera escolar, para liberar la siguiente información estudiantil a los proveedores de servicios de visión identificados y para conducir la evaluación del programa, información de contacto de la familia, número de estudiante estatal y resultados de evaluaciones y tratamientos de visión.

Esta autorización expira cuando el niño dejé OPS o se gradué. Yo entiendo que puedo revocar esta autorización en cualquier momento al entregar una carta para la Escuela Pública de Omaha, Servicios de Información Estudiantil, 3215 Cuming Street, Omaha, NE 68131-2024 o al marcar la casilla para revocar abajo.

Centro de Salud Basado en la Escuela	☐ No ☐ Sí	Yo autorizo a Centro Comunitario OneWorld y Charles Drew a examinar y tratar a mi hijo como se describe arriba. Yo autorizo a OPS a liberar la información como se describe arriba.
Servicios Dental	☐ No ☐ Sí	Yo autorizo a mi hijo a recibir servicios dentales a través de UNMC, OWCHC, CDHC y/o Creighton. Yo autorizo a OPS a liberar la información como se describe arriba.
Servicios de Visión	☐ No ☐ Sí	Yo autorizo a mi hijo a recibir servicios de visión a través de Children's y/u otros proveedores de servicios contratados como se menciona arriba. Yo autorizo a OPS a liberar la información como se describe arriba.

______________________	______________________	______________________
Firma del padre/tutor	Relación con los hijos	Fecha

Las Escuelas Públicas de Omaha no discriminan fundamentado en la raza, color, origen nacional, religión, sexo (incluyendo embarazo), estado civil, orientación sexual, discapacidad, edad, información genética, identidad de género, expresión de género, estatus migratorio, estatus de veterano, afiliación política o estatus económico en sus programas, actividades y empleo, y proporciona acceso equitativo a los "Boy Scouts" y a otros grupos juveniles designados. Las siguientes personas ha sido designadas para aceptar cualquier queja en relación a las políticas de no discriminación: El Superintendente de las Escuelas, 3215 Cuming Street, Omaha, NE, 68131 (531-299-9823). La siguiente persona ha sido asignado para manejar quejas referentes a las políticas de no discriminación: El Director para la Oficina de Equidad y Diversidad, 3215 Cuming St, Omaha, NE 68131 (531-299-0307).

Para el Uso De La Oficina Solamente ☐ Verified ☐ Programs ☐ Sections Initials

Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

CONSENT TO TREAT

Authorization for Health Care

Patient's name: ____

Please read and review each section and sign where prompted.

1. **Authorization for Medical Treatment.** I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment, as deemed necessary by Charles Drew Health Center, Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center, Inc. facility will follow the instructions of my provider(s) in the position in said care.

2. **Patient Care.** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.

3. **Personal Valuables.** I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center, Inc. maintains no responsibility for property that is personal and in my possession.

4. **Duration and Scope.** I understand this agreement will be valid for one year (12 months) from the date it is signed, unless I cancel it sooner. This agreement will apply to any care provided to the patient at any Charles Drew Health Center Inc. locations during the next year, unless the care provided requires additional consents by law.

5. **Physician and Staff Employment.** Some providers at Charles Drew Health Center Inc. may be independent contractors who use Charles Drew Health Center Inc. facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill Charles Drew Health Center Inc. may submit. Contractors are responsible for their own actions and Charles Drew Health Center Inc. is not liable for their actions or failure to act.

6. **Assignment of Facility Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Charles Drew Health Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicare and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.

7. **Assignment of Professional Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to all physician(s), therapist(s), and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

8. **Authorized Representative.** I hereby authorize Charles Drew Health Center Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).

9. **Statement of Responsibility.** I understand that I am financially responsible to Charles Drew Health Center Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.

10. **Sliding Fee Discount Program Policy.** Charles Drew Health Center Inc. has a sliding fee discount program and I may ask about it at any time. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request a sliding fee application at any time.

11. **Self-Payment.** I understand I may choose to not have Charles Drew Health Center Inc. bill my and/or the patient's insurance for a particular health care item or service provided to the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify Charles Drew Health Center Inc. in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

12. Authorization to Release Information to Insurance Company/Third Party Payer. I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. This Facility will endeavor to protect the confidentiality of my medical records. However, the Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed.

13. Non-covered Medicare/Medicaid Services. The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

14. Shadowing and Observation. Some people involved in patient's care may be medical, nursing, or other health care personnel in training. I consent to their participation. Other non-Charles Drew Health Center Inc. staff members may observe the patient's care. I have the right to request that any of these individuals not participate in or observe the patient's care and this request will not affect the patient's care at Charles Drew Health Center Inc.

15. Contact by Phone. By providing Charles Drew Health Center Inc. with my land line and/or cell phone number(s), I give my express consent for Charles Drew Health Center Inc., its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages regarding accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

16. Advanced Instructions for Healthcare. I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

__________ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Patient Rights and Responsibilities.

__________ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Privacy Practices.

HIV Consent. I hereby authorize Charles Drew Health Center to test my blood and the Counseling, Testing and Referral/Partner Counseling and Referral Services (CTR/PCRS) of the Nebraska Department of Health & Human Services Infectious Disease Section, HIV/AIDS Prevention (DHHS) to provide the confidential and anonymous laboratory analysis for the HIV antibody.

☐ I wish to be tested confidentially ☐ I wish to be tested anonymously ☐ I wish to **refuse HIV testing**

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Parent/Power of Attorney/Guardian Signature: ______________________ Date: __________

Responsible Party's Signature (if not the same as patient/parent): ______________________

Insured's Signature: ______________________ Witness to Signature: ______________________

Patient unable to sign consent because: ______________________

SBHC RELEASE OF INFORMATION

Please read the following statements and fill out information where prompted

Child name: ______________________ Birth date: ______________

Parent/Guardian name: ______________________ Phone: ______________________

Address: ______________________ Apt #: ________ City: ______________ State: ________ Zip: __________

As the parent or legal guardian of a child enrolled in the school based health center, I understand that the sharing of information related to my child's care with certain school staff, and the child's Primary Care Physician (PCP) may support care coordination for my child. The purpose of the disclosure is to allow Charles Drew Health Center ("Charles Drew") to provide OPS certificated staff, school contacts, and my PCP with information about my child's health status, medications, treatments, and clinic visits which is important for my child's safety and to promote the health and educational success of my child.

I give permission for Charles Drew staff to furnish records and discuss details regarding my child's care and treatment to my Primary Care Physician (PCP). The child's PCP is ______________________________

Please choose one: ☐ Yes ☐ No ☐ Does not apply

I hereby authorize any staff of Charles Drew to furnish records and to discuss details of child's care and treatment at the school-based health center with certificated staff (school nurses, counselors, teachers, therapists, administrators) at Omaha Public Schools (OPS). By marking "yes," I give permission for Charles Drew staff to exchange information with school personnel and/or Methodist Community Counseling or CHI counseling staff (if applicable) about my child and/or my child's treatment or medical care for the duration of my child's care.

Please choose one: ☐ Yes ☐ No ☐ Does not apply

By signing, below, I understand and acknowledge that:

1. Charles Drew will not refuse to services to my child if I refuse to sign this Authorization.
2. Medical information that is disclosed because of this Authorization may be subject to re-disclosure by the recipient and no longer protected by State Law.
3. The authorization remains effective while my child is enrolled in the Omaha Public Schools. This authorization automatically expires when my child is no longer enrolled in the Omaha Public Schools.
4. I understand that I may revoke this Authorization at any time by giving written notice to the medical professional or medical assistant on duty at the school-based health center where my child receives services.
5. I understand that my revocation is not effective as to disclosures already made and actions already taken based upon this Authorization.
6. I have received a copy of this document.

Dates of Service From: ______________________ To: ______________________

Information to be disclosed

☐ Abstract: Notes and/or Labs
☐ The entire health record including alcohol and substance testing or treatment, HIV/AIDS status or related information and Reproductive Health.
☐ Discharge Summary
☐ H/P
☐ Labs ONLY
☐ Radiology
☐ Immunizations
☐ Complete medical records, including progress notes, visit notes, labs and X-ray reports.

Specific authorization for Release of Information protected by State or Federal Law

☐ Mental health testing, counseling and treatment information
☐ Chemical dependency (drug and alcohol)
☐ STD/HIV
☐ Other: ______________________

For purpose of: ☐ Continuity of care ☐ Personal reasons ☐ Legal reasons ☐ Moving ☐ Transfer of care ☐ Other

Signature of patient or legal guardian: ______________________ Date: ______________

Relation to patient (if not self): ______________________

EXPIRATION: This authorization is effective for 12 months but no longer than one year from the date on which it was signed.

Note: *A parent or legal guardian must sign if patient is a minor (NE – under age 19. IA – under age 18) except for reproductive health and HIV testing. If signed by a patient's authorized representative, supporting legal documentation must accompany this form.*
Notice to Recipient: The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted (42CFR Part 2). A general authorization for release of protected health information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Effective Date: July 1, 2019

Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No
School-Based: ☐ Yes ☐ No
Barrier: ____________

PATIENT REGISTRATION FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: ____________ Last Name: ____________

Preferred Name: ____________ Middle Initial: ____________

Social Security Number (SSN): ____________ Date of Birth (mm/dd/yyyy): ____________
Optional

School Attending: ____________
If applicable

Address: ____________ City: ____________ State: ______ Zip: ______

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: ____________ May we leave a voicemail? ☐ Yes ☐ No

May we text this number? ☐ Yes ☐ No

☐ Home Phone: ____________ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: ____________ May we leave a voicemail? ☐ Yes ☐ No

Email Address: ____________

Emergency Contact: ____________

Relationship to Patient: ____________ Phone Number: ____________

Preferred Language: ____________ Interpreter Needed?: ☐ Yes ☐ No

How did you hear about Charles Drew Health Center, Inc.? ____________

Please check which of the following best describes your sex assigned at birth:

☐ Male ☐ Female

Please check which of the following best describes your gender identity:

☐ Male ☐ Female ☐ Transgender male/female-to-male ☐ Transgender female/male-to-female

☐ Choose not to disclose ☐ Don't know/Not applicable

Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

PATIENT REGISTRATION FORM

Please check which of the following best describes your sexual orientation:

- [ ] Straight/heterosexual
- [ ] Lesbian, gay or homosexual
- [ ] Something else
- [ ] Bisexual
- [ ] Choose not to disclose
- [ ] Don't know/Not applicable

Please check which of the following best describes your preferred pronouns:

- [ ] He, Him, His
- [ ] She, Her, Hers
- [ ] They, Them, Theirs
- [ ] Ze, Hir
- [ ] Decline to answer
- [ ] Unknown
- [ ] Other: ____________________

Please provide information on your medical provider:

Primary Medical Provider: ____________________ [ ] None/Unknown

Address: ____________________ City: __________ State: ______ Zip: ______

Please provide information on your dental provider:

Primary Dental Provider: ____________________ [ ] None/Unknown

Address: ____________________ City: __________ State: ______ Zip: ______

Please check which of the following best describes your current housing. Please only select one:

- [ ] Homeless shelter
- [ ] Transitional housing
- [ ] Doubling up
- [ ] Street
- [ ] Section 8
- [ ] Public housing
- [ ] Rent/Own

Please answer the following questions:

Are you a veteran? [ ] Yes [ ] No

Are you a migrant farm worker? [ ] Yes [ ] No [ ] Seasonal

Please check which of the following best describes your race. Please only select one:

- [ ] American Indian or Native Alaskan
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian
- [ ] Pacific Islander
- [ ] White
- [ ] More than one race
- [ ] Unknown, not listed, or refuse to report

Please check which of the following best describes your ethnicity. Please only select one:

- [ ] Hispanic, Latino, or Chicano
- [ ] Non-Hispanic, Latino, or Chicano
- [ ] Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

- [ ] Medicaid
- [ ] Medicare
- [ ] Private or commercial insurance (including through Marketplace)
- [ ] None or uninsured

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"Growing a Healthy Community"

PATIENT REGISTRATION FORM

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **CIRCLE** your family size and household income range (should be in the same row).

Family Size:	Annual Income Ranges:					
1	$0 - 12,760	$12,761 - 15,950	$15,951 - 19,140	$19,141 - 22,330	$22,331 - 25,550	Over $25,550
2	$0 - 17,240	$17,241 - 21,550	$21,551 - 25,860	$25,861 - 30,170	$30,171 - 34,480	Over $34,480
3	$0 - 21,720	$21,721 - 27,150	$27,151 - 32,580	$32,581 - 38,010	$38,011 - 43,440	Over $ 43,440
4	$0 - 26,220	$26,221 - 32,750	$32,751 - 39,300	$39,301 - 45,850	$45,851 - 52,400	Over $52,400
5	$0 - 30,680	$30,681 - 38,350	$38,351 - 46,020	$46,021 - 53,690	$53,691 - 61,360	Over $61,360
6	$0 - 35,150	$35,151 - 43,950	$43,951 - 52,740	$52,741 - 61,530	$61,531 - 70,320	Over $70,320
7	$0 - 39,640	$39,641 - 48,550	$48,551 - 59,460	$59,461 - 69,370	$69,371 - 79,280	Over $79,280
8	$0 - 44,120	$44,121 - 55,150	$55,151 - 66,180	$66,181 - 77,210	$77,212 - 88,240	Over $88,240

SECTION III: RESPONSIBLE PARTY INFORMATION

Only complete this section if the responsible party is different from patient.

First Name: ______________________ Last Name: ______________________

Preferred Name: ______________________ Middle Initial: __________

Social Security Number (SSN): ______________________ Date of Birth (mm/dd/yyyy): ______________________
Optional

Address: ______________________ City: __________ State: ______ Zip: __________

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Home Phone: ______________________ May we leave a voicemail? ☐ Yes ☐ No

☐ Cell Phone: ______________________ May we leave a voicemail? ☐ Yes ☐ No

May we text this number? ☐ Yes ☐ No

☐ Alt. Phone: ______________________ May we leave a voicemail? ☐ Yes ☐ No

Email Address: ______________________

Preferred Language: ______________________ Interpreter Needed?: ☐ Yes ☐ No

SECTION IV: INSURANCE INFORMATION

Insurance Name: ______________________ Policy number/Enrollment ID: ______________________

Group ID: ______________________ Member ID: ______________________

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: ______________________ Date: __________

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SBHC HEALTH HISTORY

Patient Name: ______________________________ Date: __________

Patient Medical History

Does your child have allergies? ☐ Yes ☐ No
Medicines: ______________________
Foods: ______________________
Latex: ______________________
Other: ______________________

Is your child taking medicine? ☐ Yes ☐ No
If yes, which ones? ______________________

Were there any problems with the pregnancy or birth of your child? ☐ Yes ☐ No
If yes, what were they? ______________________

Any serious injuries or accidents? ☐ Yes ☐ No
If yes, what are they? ______________________

Have you taken your child to the hospital recently? ☐ Yes ☐ No
Where? ______________________
Date? ______________________

Has your child been to clinics or urgent care centers for any health problems recently? ☐ Yes ☐ No
Where? ______________________
Date? ______________________

Does your child have any serious illnesses or medical conditions (like asthma, diabetes, anemia or infections)? ☐ Yes ☐ No
If yes, what are they? ______________________

Has your child ever spent the night in the hospital? ☐ Yes ☐ No
Where? ______________________
For what? ______________________

Has your child ever had surgery? ☐ Yes ☐ No
Where? ______________________
For what? ______________________

Patient Immunization History

Any your child's immunizations current? ☐ Yes ☐ No

Has your child had the chicken pox? ☐ Yes ☐ No

When was your child's last flu vaccine? Date: __________

When was your child's last tetanus vaccine? Date: __________

Which of the following illnesses has your child had?

Illness	Yes	No
Asthma?	☐ Yes	☐ No
Allergies?	☐ Yes	☐ No
Eye problems?	☐ Yes	☐ No
Ear infections?	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No
Tuberculosis? *(Active or LTBI)*	☐ Yes	☐ No
Heart problems?	☐ Yes	☐ No
Chest pain or pressure?	☐ Yes	☐ No
Liver disease? *(Hepatitis)*	☐ Yes	☐ No
Gastrointestinal problems? *(GERDS, MSPI)*	☐ Yes	☐ No
Urine infections?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No
Fainting or almost passing out?	☐ Yes	☐ No
Head injury/concussion?	☐ Yes	☐ No
Immune problems? *(HIV, AIDs, etc.)*	☐ Yes	☐ No
Mononucleosis?	☐ Yes	☐ No
ETOH/Drug abuse	☐ Yes	☐ No
Sprains/strains/broken bones	☐ Yes	☐ No
Any special testing like xrays, MRIs	☐ Yes	☐ No
Mental health issues?	☐ Yes	☐ No

Other, please explain: ______________________

Family Information

Who currently lives at home? ☐ Mother ☐ Father ☐ Siblings ☐ Other: ____________

Does someone else care for your child? ☐ Yes ☐ No
Example: Daycare/after school care

Does the mother work? ☐ Yes ☐ No

Does anyone in the house smoke? ☐ Yes ☐ No

Family Medical History

Condition	Yes	No
Birth defects?	☐ Yes	☐ No
Intellectual disability?	☐ Yes	☐ No
SIDS?	☐ Yes	☐ No
Deafness?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No
Allergies?	☐ Yes	☐ No
Tuberculosis? *(Active or LTBI)*	☐ Yes	☐ No
Sudden death for no reason or from a heart problem?	☐ Yes	☐ No
Heart disease?	☐ Yes	☐ No
High blood pressure?	☐ Yes	☐ No
High cholesterol?	☐ Yes	☐ No
Liver disease? *(Hepatitis)*	☐ Yes	☐ No
Kidney problems?	☐ Yes	☐ No
Gastrointestinal problems? *(GERDS, MSPI)*	☐ Yes	☐ No
Anemia?	☐ Yes	☐ No
Bleeding disorders?	☐ Yes	☐ No
Immune problems? *(HIV, AIDs, etc.)*	☐ Yes	☐ No
Epilepsy?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No
Mental health issues?	☐ Yes	☐ No
ETOH/Drug abuse	☐ Yes	☐ No

Other, please explain: ____________________________

____

____

____

General Health Questions

Do you have concerns regarding your child's physical, mental, and/or emotional development? ☐ Yes ☐ No
If yes, what are they? ____________________________

____

____

Do you have concerns regarding your child's school performance? ☐ Yes ☐ No
If yes, what are they? ____________________________

____

____

Is your child involved in special education classes/services? ☐ Yes ☐ No
If yes, what are they? ____________________________

____

____

Do you have concerns your child to be in good health? ☐ Yes ☐ No
If no, what are your additional concerns? ____________________________

____

____

Primary Care Provider and Pharmacy Information

Primary Care Provider: ____________________________
Address: ____________________________

Preferred Pharmacy: ____________________________
Address: ____________________________

Any additional providers your child sees regularly?
Provider Name: ____________________________
Address: ____________________________
Provider Name: ____________________________
Address: ____________________________