Gateway Community Health Centers, Inc. – School Based Health Center

88 US highway 158, Gatesville, NC 27938 Phone:

Internal Use Only

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____

Sex: ❑ Male ❑ Female Grade _____

Race: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ More than one race ❑ Other _____

Ethnicity: Hispanic/Latino_____ Non-Hispanic/Latino_____

Student Address: _____

_____

_____ _____ _____
City State Zip Code

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, If Applicable
Last Name: _____ First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Cell: _____
Employer: _____
Employer Address: _____
Employer Phone: _____

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # _____

Does your child have Medical Insurance?
❑ No ❑ Yes: Plan # _____

Please complete and sign the Sliding Fee Application enclosed with this information. If you would like to apply for the sliding fee program.

PARENTAL CONSENT FOR PRIMARY CARE SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by Gateway Community Health Centers, Inc. School-Based Health Center.
My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to releasing medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

Gateway Community Health Centers Inc. - School Based Health Center

88 US highway 158, Gatesville, NC 27938 Phone:

SCHOOL-BASED PRIMARY CARE SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of GATEWAY COMMUNITY HEALTH CENTERS, INC. as part of the school health program. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Primary Care Services including screening for vision, hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, menstrual problems, chest colds, sore throats, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Routine diagnostic tests.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Referrals to Behavior Health and Substance Abuse services.
6. Health education and counseling for the prevention of risk-taking behaviors such as drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, and sexually transmitted infections.
7. Referrals for dental examinations including diagnosis, treatment, and sealants.
8. Referrals for services not provided at the School-Based Health Center.
9. Annual health questionnaire/survey.
10. Referrals will be made, and confidential services will be provided in accordance with North Carolina State Law.

FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes the release of medical information. This information may be protected in accordance to federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Gateway Community Health Centers, Inc. because it is required by law and it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the Gateway Community Health Centers, Inc. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I understand that this information will remain confidential in accordance with Federal and State law and Gateway Community Health Centers, Inc. Policies and Procedures on confidentiality:

My signature on page 1 of this form also gives my consent to GATEWAY COMMUNITY HEALTH CENTERS, INC. to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the Gateway Community Health Centers, Inc.- School Based Health Center

After-Hours Policy: After hours or when school is not in session, a provider can be reached by calling the Gateway Community Health Centers, Inc. at (252) 357-1226 and ask for Gateway Community Health Centers Provider on call. Please go directly to the nearest hospital for all emergencies.

GATEWAY COMMUNITY HEALTH CENTERS, INC.

Sliding Fee Discount Application:

It is the policy of Gateway Community Health Centers, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this health center, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME: _____ Birth Date: ____/___/____
(Last) (First) (Middle)

Address: _____ Social Security# ____-___-____
Number& Street/PO Box

_____ Phone: (____) _____-_____

Please check the following:

Patients by Hispanic or Latino Ethnicity/Race/Language

Patients By Race	Hispanic /Latino	Not Hispanic/Latino
Asian		
Native Hawaiian		
Other Pacific Islander		
Black/African American		
American Indian/Alaska Native		
White		
More than one race		
Unreported/Refused to report		
Other		

Preferred spoken language for health care:

English _____ **Japanese** _____
Spanish _____ **Italian** _____
French _____ **German** _____ **Thai** _____ **Other:** _____

Employer: _____ **Employer Telephone:** (____) _____ -

Employer: Address: _____ **Street:** _____

City: _____ **State:** _____ **Zip:** _____

FAMILY MEMBERS

(LIST ALL FAMILY MEMBERS LIVING IN YOUR HOUSE RELATED BY BLOOD, BIRTH, OR MARRIGE)

NAME	RACE	SEX	DATE OF BIRTH	RELATIONSHIP	EMPLOYMENT	SOCIAL SECURITY#

PLEASE FILL IN THE COLUMN WITH YOUR GROSS AMOUNT WHICH APPLIES TO HOW YOU ARE PAID

	Per Hour	Weekly	Bi-Weekly	Monthly	Bi-Monthly	Other	Total
Head of Household							
Spouse							
Other							

Social Security Retirement	**$**
Pensions	**$**
Veterans Benefits	**$**
Workers Compensation	**$**
S.S.I. & Disability Insurance	**$**
Railroad Retirement	**$**
Unemployment Compensation	**$**
Welfare	**$**
Support or Alimony Payment	**$**
Rental Income	**$**
Interest Income	**$**
Total Household Income	**$**

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

Signature: _____

DATE: ____/____/____: Approval Date: _____: Sliding Fee Scale_____:

Employee Signature: _____

Patient Declined Sliding Fee:

Patient Signature: _____ **Date:** _____