Northern Oswego County Health Services, Inc. **School Based Health Center Enrollment Form**

☐ APW High School ☐ Lura Sharp Elementary ☐ Pulaski Middle Senior High ☐ Sandy Creek Central School
☐ APW Elementary School ☐ Mexico Middle School ☐ Sandy Creek Dental Program

Patient/Parent/Guardian Information

Patient First Name	Patient Last Name	M	Date of Birth	Social Security Number	Sex M F
Parent/Guardian First Name	Parent/Guardian Last Name	M	Date of Birth	Social Security Number	Relationship
Parent/Guardian First Name	Parent/Guardian Last Name	M	Date of Birth	Social Security Number	Relationship

Street Address/PO Box	City	State	Zip Code

Contact Information

Home Telephone Number	Emergency Contact Name	Emergency Contact Telephone Number	Home E-mail Address
Mom Work Telephone Number	Dad Work Telephone Number	Mom Cell Number	Dad Cell Number

Statistic Information for reporting purposes:

Race: ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/African American ☐American Indian/Alaska Native
☐ White ☐ More than one race ☐ Refuse
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

Number of people in the household: _____ Annual Household Income: _____

Insurance Information: (Please attach a copy of the insurance cards)

☐ No Insurance	☐ Medicaid	Medicaid Number	Sequence Number
Primary Insurance Company	Insured Name /Date of Birth	ID Number	Group Number
Insurance Address	Employer	Insurance Eligibility Date	Please attach a copy of the Insurance Card
Secondary Insurance Company	Insured Name/Date of Birth	ID Number	Group Number
Insurance Address	Employer	Insurance Eligibility Date	Please attach a copy of the Insurance Card

☐ I am interested in receiving insurance options available to me and my family.

Primary Healthcare Information:
☐ My child ***does not*** have a Primary Care Provider and would like the School Based Health Center to be the Primary Care Provider
☐ My child has a Primary Care Provider but would like to access care from the School Based Health Center when necessary

Primary Care Provider Name	Address	Telephone Number
Dentist Name	Address	Telephone Number
Pharmacy Name	Address	Telephone Number

In the case of an Emergency which Hospital would you prefer your child be transported to? _____

Does your child have any medication allergies? ☐ Yes ☐ No Does your child have any environmental allergies? ☐ Yes ☐ No

If yes please list allergies: _____

_____

Patient First Name	Patient Last Name	M	Date of Birth

Patient Birth History:

Birth Weight: _____ Length: _____ Place of Birth: _____

Did your child have any serious medical problems? ☐ Yes ☐ No
If yes please list: _____

_____

Patient Medical History:

Is your child taking any medications? ☐ Yes ☐ No

If yes please list medications: _____

Has your child had any of the following?

☐ Diabetes	☐ Bleeding Problems	☐ Colds (6 or more per year)	☐ Convulsions or Fainting
☐ Eye Problems	☐ Kidney Problems	☐ Sleeping Problems	☐ Heart Problems
☐ Asthma	☐ Chicken Pox	☐ Mumps	☐ 3 Day Measles
☐ Nerve Problems	☐ Ear Infections	☐ Problems Urinating	☐ 10 Day Measles
☐ Broken Bones	☐ Dental Problems	☐ Whooping Cough	☐ Pneumonia
☐ Health Problems			

☐ Yes ☐ No Serious Accidents: _____

☐ Yes ☐ No Operations/Surgery: _____

☐ Yes ☐ No Hospital Visits – Overnight: _____

Other, please describe: _____

Behavior and School:

☐ Yes ☐ No Does your child get along well in school? _____

Does your child suffer from any of the following?

☐ Fussiness	☐ Won't Mind	☐ Holds Breath	☐ Jealousy	☐ Thumb Sucking	☐ Nail Biting
☐ Bed Wetting	☐ Overactive	☐ Slow Learner	☐ Bad Temper	☐ Speech Problems	☐ Can't Toilet Train
☐ Miserable/ Withdrawn		☐ Eats Dirt, Paint, or Glue		☐ Doesn't Pay Attention	

Other, please explain: _____

Family History:

Has any family members had any of the following:

☐ Diabetes	☐ Bleeding Disorder	☐ Cancer	☐ Kidney Problems	☐ Recent Contagious Disease
☐ Heart Disease	☐ Low Blood Pressure	☐ Anemia	☐ High Blood Pressure	☐ Drinking Problem/Alcoholism
☐ Asthma	☐ Sickle Cell Anemia	☐ Tuberculosis	☐ Mental Retardation	☐ Nervous Breakdown
☐ Drug Problems	☐ Rheumatic Fever	☐ Mental Problems		

Other, please explain: _____

☐ Yes ☐ No Is there anything that concerns you about your child that you would like us to be aware of?

Concerns: _____

Thank you for completing this form. We look forward to participating in your child's health care!

Parental Request for Health Services and Authorization Release of Medical Information to Process Insurance Claims

I hereby give my consent for my child to receive health care services provided by the staff of the Northern Oswego County Health Services, Inc.'s School Based Health Center program, including:

- Complete physical checkups (mandated physicals, sports physicals, working papers)
- First aid and assessment of acute illness
- Lab tests when necessary to detect illness or infection
- Hearing, vision, scoliosis and blood pressure screening
- Immunizations and allergy injections (by order of an allergist)
- Dental screening and fluoride treatments
- Prescriptions when necessary
- Care for skin problems
- Nutrition and weight counseling
- Health education and counseling
- Counseling for school and personal problems
- Referral to outside agencies (specialists, counselors, etc.) for services not provided at the School Based Health Center

Additional services offered for teens include:

- Alcohol and drug abuse and prevention counseling
- Counseling regarding puberty, peer pressure, communication and responsible decision making (in accordance with national, state, and local school guidelines)
- Counseling regarding options of pregnancy prevention, including abstinence and contraception, when necessary or at the request of the parent or guardian

I authorize the release of necessary medical information to my designated insurance carrier for claims, and direct that any insurance payments be sent to Northern Oswego County Health Services, Inc.

If my child's primary care provider (PCP) is not affiliated with Northern Oswego County Health Services, Inc., I authorize the release of medical information to my child's PCP (given on the School Based Health Center registration form) unless otherwise specified.

I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment of or advice regarding alcoholism, drug abuse, sexually transmitted diseases, pregnancy or contraception.

The staff of the Northern Oswego County Health Services, Inc.'s School Based Health Center program considers parental involvement very important. Accordingly, the staff will encourage every student to involve his or her parents or guardians in all counseling and medical care decisions.

Child's Name:	
Your name and relationship to the child:	
Signature:	Date:

Patient Consent Form rev. 8.19.2008

Northern Oswego County Health Services, Inc.

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical/dental or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare/dental services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. By signing this consent form, you have acknowledged that you have received/been made aware of our ***Notice of Privacy Practices.***

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restriction.

If you do not sign this Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this.

Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

PRINT PATIENT
NAME:_____DOB:_____
If minor, parent who has physical custody of minor:_____
I have the authority to give permission for treatment: ___yes ___no
I authorize _____to consent for treatment in my absence.
(step-parent, grandparents, etc)

PRINT PATIENT'S REPRESENTATIVE NAME:_____

PRINT REPRESENTATIVE'S RELATIONSHIP:_____

SIGNATURE OF PATIENT OR REPRESENTATIVE:_____

DATE:_____ WITNESS SIGNATURE_____

Northern Oswego County Health Services, Inc. (NOCHSI)
61 Delano Street, Pulaski, NY 13142

PATIENT'S BILL OF RIGHTS

Patients who utilize the services of Northern Oswego County Health Services, Inc. (NOCHSI) are guaranteed the right to:

- Understand and use these rights. If for any reason you do not understand or you need help, we will provide assistance, including an interpreter.
- Receive treatment without discrimination as to race, color, creed, national origin, sex, religion, handicap, age, disability, sexual orientation, or source of payment.
- Receive considerate and respectful care in a clean and safe environment.
- Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.
- Receive complete information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- Receive all the information you need to give informed consent for an order not to resuscitate, you also have the right to designate an individual to give this consent if you are too ill to do so.
- Refuse treatment and be told what effect this may have on your health.
- Refuse to take part in research.
- Participate in all decisions about your treatment.
- Obtain a copy of your medical record for which we can charge a reasonable fee.
- Receive an itemized bill and explanation of all charges.
- Complain without fear of reprisals about the care and services you receive and to have the center respond to you and you request it, a written response. If you are not satisfied with the center's response, you can complain to the NYS Health Department at 477-8592 or the Joint Commission (JC) at 1-800-994-6610 or email them at complaint@jointcomission.org.
- To be assessed and managed for pain.
- Be assured that privacy and confidentiality of your protected health information will be strictly maintained.
- Patient has the right to approve or refuse the release or disclosure of the contents of their medical record to any health care practitioner or health care facility except as required by law or third party payment contract.

PATIENT'S RESPONSIBILITIES

Patients are to assume reasonable responsibilities related to their health and health care. These include becoming involved in your own or family health care decisions.
Your responsibilities are:

- Always bring your insurance card(s) when coming for services. Be aware of the services covered by your policy and the providers who participate with your plan.
- Bring your children's immunizations records when you bring them to see their physician.
- Inform the health center of any changes in your address, telephone number or name of employer as soon as possible.
- Pay for professional services rendered on the day of services or make other arrangements with the Billing Office in advance.
- Make and be on time for appointments. If you cannot keep an appointment advise the Health Center 24 hours prior to your appointment or as early as possible, so that another patient may be scheduled in your place and your appointment rescheduled.
- Be aware of the Center's NO SHOW POLICY and make every effort possible to keep scheduled appointments.
- Reschedule appointments that you cannot keep at referral centers, e.g. to see a specialist or have a special procedure done.
- Be honest about medical instructions of the Health Center staff. If for any reason you feel you cannot or should not follow advice, talk to the staff member right away. Be sure you understand instructions from Health Care Provider.
- Bring with you to the Health Center, the name and address of other physicians or dentists that you have been seeing. Bring a list of medicines that you are taking. This will enable the Health Center staff to provide you with better health care.
- Be polite and considerate of other patients and respect their privacy.
- Bring the physical form with you to the exam.
- Call for your prescriptions 1 week ahead of time.
- If you are a walk in patient, please remember scheduled patients will be seen first, you will be worked in.