ConnextCare™
A Community of Care

SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

Please indicate your enrolled school district and program choices

- ❑ **APW** Elementary Medical
- ❑ **APW** Elementary Dental
- ❑ **APW** Middle Senior High Medical
- ❑ **APW** Middle Senior High Dental
- ❑ **Mexico** Elementary/High School Medical
- ❑ **Mexico** Elementary/High School Dental
- ❑ **Mexico** Middle School Medical
- ❑ **Mexico** Middle School Dental
- ❑ **Sandy Creek** Medical
- ❑ **Sandy Creek** Dental
- ❑ **Fairgrieve** Elementary Dental
- ❑ **Lura Sharp** Elementary Medical
- ❑ **Pulaski** Middle Senior High Medical

Today's Date: _____

PATIENT/PARENT/GUARDIAN INFORMATION

Patient Name (First, Last, MI) _____ Date of Birth _____ SS # _____ ☐ Male ☐ Female

Parent/Guardian #1 Name _____ Date of Birth _____ SS # _____ Relationship _____

Parent/Guardian #2 Name _____ Date of Birth _____ SS # _____ Relationship _____

Street Address/PO Box _____ City _____ State _____ Zip Code _____

Mother's Maiden Name _____ Student's Current Grade Level _____

CONTACT INFORMATION

Home Telephone Number _____ Home Email Address _____

Parent/Guardian #1 Cell # _____ Parent/Guardian # 1 Work # _____

Parent/Guardian #2 Cell # _____ Parent/Guardian # 2 Work # _____

Emergency Contact Name _____ Emergency Contact Number _____

STATISTIC INFORMATION FOR REPORTING PURPOSES

Race: ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian/Alaska Native

☐ White ☐ Black/African American ☐ More than one race ☐ Refuse

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

Number of people in the household _____ Annual Household Income $_____ ☐ Refuse to Report

INSURANCE INFORMATION (Please attach a copy of the insurance cards)

☐ No Insurance ☐ I am interested in receiving insurance options available to me and my family.

Medicaid # _____ Sequence # _____

Primary Insurance _____ Insured Name/Date of Birth _____ Employer _____

ID # _____ Group # _____ Insurance Address _____

Secondary Insurance _____ Insured Name/Date of Birth _____ Employer _____

ID # _____ Group # _____ Insurance Address _____

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 _____ Phone # _____

Date of Last Physical Exam _____

Name/Location of Pharmacy _____ **Telephone #** _____

Patient Name (First, Last, MI) _____ Date of Birth _____

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

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

If yes, please list allergies _____

_____

PATIENT BIRTH HISTORY

Birth Weight _____ Length _____ Place of Birth _____

☐ Yes ☐ No Did your child have any serious medical problems?

If yes, please list _____

_____

PATIENT MEDICAL HISTORY

Is your child taking any medications? ☐ Yes ☐ No

If yes. please list _____

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	☐ Problems Urinating	☐ Ear Infections
☐ 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 _____

FAMILY HISTORY

Have 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	☐ Developmental Disabled	☐ Nervous Breakdown
☐ Drug Problems	☐ Rheumatic Fever	☐ Behavioral Health Issues		

Other, please explain _____

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

Concerns _____

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

Other, please explain _____

CONNEXTCARE DENTAL ENROLLMENT FORM

Would you like to enroll in dental services? Yes___ No___

PATIENT DENTAL HISTORY

Date of last dental exam _____ Date of last cleaning _____

Dentist Name _____ Address _____ Phone # _____

Dental Insurance _____ Insured Name/Date of Birth _____ Employer_____

ID # _____ Group # _____ Insurance Address _____

How often does your child brush their teeth? _____ Floss? _____

What concerns do you have about your child's dental health? _____

_____

☐ Yes ☐ No Does your child ever have dental pain? If so, when? _____

☐ Yes ☐ No Did your child have a negative dental experience? _____

☐ Yes ☐ No Does your child smoke or use smokeless tobacco?

☐ Yes ☐ No Has the child had orthodontic treatment?

☐ Yes ☐ No Has the child had teeth removed?

☐ Yes ☐ No Does your child have a "sweet" tooth?

☐ Yes ☐ No Has your child received any fluoride treatment? □ pills/vitamins □ topical □ water

☐ Yes ☐ No Has anyone explained importance of primary teeth?

The School-Based Health Center Dental Department will take annual x-rays, as needed, to diagnose decay (cavities) that may not be visible clinically. Please be advised that at this time x-rays are only available at the ***Sandy Creek and Mexico SBHC. Please mark one of the boxes below to consent or decline this service.

☐ Yes, my child may receive x-rays at the School-Based Health Center

☐ Yes, my child may receive Fluoride treatment at the School-Based Health Center

☐ No, please only diagnose visible decay

☐ N/A, my child's school does not offer x-rays at this time

_____ _____

Signature of Parent/Guardian Date

Thank you for completing this form.

We look forward to participating in your child's health care!

ConnextCare
School Based Medical/Dental Program

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

Authorization for Release of Medical/Dental Information

I have the authority to give permission for treatment and hereby authorize ConnextCare or its representatives to provide medical/dental care. I hereby authorize payment directly to ConnextCare for services rendered and authorize the release of any medical/dental information necessary to process insurance claims.

If my child's Primary Care Provider (PCP) or Primary Dental Provider (PDP) are not affiliated with ConnextCare, I authorize the release of medical/dental information to or from my child's PCP (given on the School Based 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. The staff of ConnextCare's School Based Medical/Dental programs considers parental involvement very important. Accordingly, the staff will encourage every student to involve his or her parents or guardians in all medical/dental care decisions.

- ☐ I consent to have the SBHC and School Nurse share my child's required NYS physical information with one another
- ☐ I decline consent to release records to and from my child's PCP/PDP for the purpose of extended care coordination

Parental Consent for Medical/Dental Services

I hereby give my consent for my child to receive applicable medical/dental care services provided by the staff of ConnextCare's School Based Medical/Dental program, including:

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

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 and Patient Bill of Rights before signing this Consent Form or at any time by request. The most current Notice of Privacy Practices and Patient Bill of Rights can also be found on our Website at www.connextcare.org. By signing this consent form, you have acknowledged that you have received/been made aware of our ***Notice of Privacy Practices*** and our ***Patient Bill of Rights***.

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. 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.

By signing this form you understand that photographs, videotapes, digital, or other images may be required to document care, and consent to this. Images that identify you will be released and/or used outside the institution only upon written authorization from you or your legal representative.

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.

I authorize _____ or _____to consent for treatment in my absence
(Name & Relationship) (Name & Relationship)

You have the right to revoke this consent in writing at any time, except where we have already made disclosures in reliance on your prior consent.

_____

SIGNATURE OF PARENT/GUARDIAN **PRINT NAME and RELATIONSHIP**

_____

SIGNATURE OF WITNESS **DATE**

ConneXtCare
A Community of Care

61 Delano Street, Pulaski, New York 13142-1400
Phone: (315) 298-6569 Fax: (315) 298-7488 TDD: 711
www.connextcare.org

Pulaski Location
61 Delano Street
Pulaski, New York 13142
Phone: 315- 298-6564 Fax: 315- 298-3968

THIS SECTION IS FOR OFFICE USE ONLY
Date Received _____
Date Completed _____
By_____

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name (Include any Maiden names &/or Alias)	Date of Birth	Medical Record Number
Patient Address	SS#	Phone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS related information only if I place my initials on the appropriate line in item 9. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug, Substance Use Disorder treatment (SUD), or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS/SUD/MH related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signed this form.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in Item 2), and this re-disclosure may no longer be protected by federal or state law. I understand that in compliance with New York State statute, I shall pay a fee of $.75 per page or $3.00 (whichever is less). There is no charge for referral care of follow up treatment.

6. Name, Phone Number, Fax Number, and Address of Provider or Entity to Release this Information:

7. Name, Phone Number, Fax Number, and Address of Person(s) to Whom this Information Will Be Disclosed:

8. Reason for Release of Information:
☐ Changing Primary Care Physician ☐ Specialist/Referral/Continuity of Care ☐ Legal or Insurance purposes ☐ Other:_____

9. Unless previously revoked by me, the specific information below may be disclosed from:_____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except: _____
☐ Only the following specific information: _____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS related Information		

10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
WITNESS SIGNATURE DATE

This form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

ConnextCare

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**