HealthPoint Family Care

School Based Health Center Patient Profile

School:

Student Name:_____ **Date of Birth:**_____ **Male / Female**

Address:_____ **Social Security #:**_____

City/Zip:_____ **Preferred Language:** English Spanish _____

You agree we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Home Phone Number:_____ **Parent Cell Phone Number:**_____

Parent Work Phone:_____ **Parent Email Address:**_____

Race: [ ]White/Caucasian [ ]Black/African American [ ]More than One Race [ ]Asian [ ]Native American [ ]Other

Ethnicity: [ ]Hispanic [ ]Non Hispanic **Your Relationship to Child:** [ ]Parent [ ]Foster Parent [ ]Legal Guardian

PARENT OR GUARDIAN INFORMATION:

Name:_____

Address:_____

City / Zip:_____

BILLING TO INFORMATION:
Check here [ ] if same as Parent/Guardian

Name:_____

Address:_____

City / Zip:_____

Please list your total household annual income

$ _____ # of People in Home _____

Income information is collected to support having health and dental programs in the schools. All district students are eligible.

I wish to enroll my child for: ☐ Medical Services

Medical Fees

- All patients who do not have Medicaid, Medicare or Private medical Insurance will be self pay and will be billed $30 per medical visit at the school based health center. Vaccinations are included in the $30 visit copay.
- HealthPoint will bill Anthem and United HealthCare plans if there is no PCP or a HealthPoint Provider is selected as the PCP (preferred provider). The insurance plan copay will be billed.
- Any patient with private insurance except a plan above will be billed $55 per medical visit. Vaccines are an additional fee. No other private insurances are accepted or billed by HealthPoint.

My child has (Check All That Apply):

NO insurance ☐

Private medical insurance ☐ ***circle if:*** **Anthem/UHC/Other I**D #:_____ Group #_____PCP:_____

Medicaid ☐ ***circle if:*** **Wellcare or Coventry** **ID # Required:**_____

A billing statement for private insurance patients and self pay patients will be mailed to the billing information address above. Payment is expected in 20 days.

Consent to Treat A Minor Child

Completing this section will allow HealthPoint providers to examine and treat the minor child named below for simple illnesses or routine physicals including immunizations without a parent or guardian being present at the office or school health center.

Print Child's Name:_____ **Birth Date:**_____

I, _____, the parent/guardian of _____, give consent for ongoing assessment/evaluation/treatment of my child at HealthPoint offices, including school health centers. Evaluation and treatment of the child at the office will be done by a regular HealthPoint Provider. I give consent for the following dental, physical and/or mental health services to be performed at HealthPoint including school health centers:

- Assessment, diagnosis, evaluation, and treatment of the child even if a parent or guardian cannot be present
- Treatment of the child may include administration of any over-the-counter medications (e.g., pain relievers, cough suppressants, etc.) except the following: _____
- Routine lab work such as a strep screen or urine check.
- Routine immunizations as required by the State.
- Routine physicals, acute illness, follow ups

The parent or guardian will be contacted for permission before additional things may be done. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

The following person(s) listed have my permission to bring/send my child to the school health center office for treatment:

The School Nurse, Teacher, School Administration and other school personnel may send my child for school based health services, or the parent or student, if age 18 or older, can contact HealthPoint or the school to schedule an appointment.

Others (Please Print Name / relationship to child):_____

_____ (Please initial) **I decline to give permission** for anyone to bring my child to the office for treatment except for school personnel. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

Release of Information

To promote continuity of care, I authorize HealthPoint Family Care to release a copy of records created at school based health visits to the primary care provider listed below and any other health care provider involved in the patient's care.

Primary Care Provider (PCP):_____ PCP Phone:_____

Authorizations

I certify the above information is correct. I hereby consent to treatment including whatever test or procedures may be directed by the medical or dental provider. I also consent to all state required immunizations. I authorize HealthPoint Family Care, Inc. to bill my insurance for services rendered. I further authorize the release of my medical and/or dental information to my insurers or responsible party. I understand that I will be responsible for all bills if there is not active Medicaid or Medicare. I authorize HealthPoint to release health records to the school required for enrollment including school physicals and immunization records. I understand it is my responsibility to notify the school based health office about changes in guardianship, address, or phone number. A new form must be filled out for change in permission status for Treatment of a Minor Child.

Signature of Parent/Guardian:_____ Print Name:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT ON NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Parent/Guardian:_____ Print Name:_____ Date:_____