



SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

What services would you like to enroll your student in? ☐ Medical ☐ Dental ☐ Counseling

STUDENT INFORMATION			
Name (First, MI, Last)		Date of Birth	Gender at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address/PO Box	City	State	Zip
School Name	Grade	SS#	Mother's Maiden Name
As a federally qualified health center, ConnexCare MUST ask you to complete the following questions:			
Gender Identity:		<input type="checkbox"/> Choose not to disclose	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> More than one race <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Not Latino <input type="checkbox"/> Choose not to disclose			
Primary language spoken at home:			
Household size & income: Number of people in household: _____ Household income per year \$ _____ <input type="checkbox"/> Choose not to disclose			
PARENT/LEGAL GUARDIAN INFORMATION: ***Person(s) who has the legal rights to make medical decisions for student***			
Name:		Name:	
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____		Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____	
<i>Please provide copy of court orders regarding custody/guardianship, if applicable</i>		<i>Please provide copy of court orders regarding custody/guardianship, if applicable</i>	
Mailing address if other than student's address:		Mailing address if other than student's address:	
Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Ok to leave Message/Text : <input type="checkbox"/> Yes <input type="checkbox"/> No		Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Ok to leave Message/Text : <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who Does Student Live With? (Check all that apply) <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Guardian <input type="checkbox"/> Step-Parent <input type="checkbox"/> Other:			
Additional Emergency Contact Name:		Phone:	
Primary Medical Insurance		Dental Insurance	
<input type="checkbox"/> The Student HAS Medical Insurance <input type="checkbox"/> The Student DOES NOT have Medical Insurance <input type="checkbox"/> I am interested in receiving insurance options		<input type="checkbox"/> The Student HAS Dental Insurance <input type="checkbox"/> The Student DOES NOT have Dental Insurance <input type="checkbox"/> I am interested in receiving insurance options	
Insurance Company Name:		Insurance company Name:	
Medical Policy #:		Dental Policy #:	
Employer:		Employer:	
Billing Address of Insurance Co:		Billing Address of Insurance Co:	
Policy Holder's Name and Date of Birth:		Policy Holder's Name and Date of Birth:	
Policy Holder's SS#		Policy Holders SS#:	
I have additional Medical Insurance (name of insurance co.)		I have additional Medical Insurance (name of insurance co.)	

I understand that it is my responsibility to notify ConnexCare of any changes to the information provided on this form and, when applicable, to provide the office with the most up-to-date custody/guardianship paperwork for my child.

Name of Person completing this form

Signature

Date

ConnexCare



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 HealthConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealthConnections 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 HealthConnections website at <http://healthconnections.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.
<input type="checkbox"/> 1. I GIVE CONSENT for the Organization named above to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).
<input type="checkbox"/> 2. I DENY CONSENT for the Organization named above to access my electronic health information through HealthConnections for any purpose, <i>even in a medical emergency.</i>

If I want to deny consent for all Provider Organizations and Health Plans participating in HealthConnections to access my electronic health information through HealthConnections, I may do so by visiting HealthConnections website at <http://healthconnections.org/> or calling HealthConnections 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 Health_eConnections 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 Health_eConnections. 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 Health_eConnections. You can obtain an updated list at any time by checking Health_eConnections website at <http://healthconnections.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 Health_eConnections 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 Health_eConnections website at <http://healthconnections.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 Health_eConnections ceases operation (or until 50 years after your death, whichever occurs first). If Health_eConnections 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 Health_eConnections 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.

ConnexCare Policies and Consents for School Based Health Center Medical Services

Student Name: _____ Date of Birth: _____

CONSENT FOR MEDICAL SERVICES:

☐ I authorize my child to receive medical services provided by the staff of the ConnexCare School Based Health Center Program.

Services may include, but are not limited to the following:

- Comprehensive physical examinations (Well Child, Sports, Working Paper etc.)
- Treatment of illness and injury
- Management of chronic medical conditions
- Primary and preventative health care
- Referral to outside agencies (specialists, counselors, etc.) for services not provided at the School Based Health Center

The ConnexCare School Based Health Care believes that parental involvement is essential in keeping children healthy and encourage each student to involve his or her parents in healthcare decisions. We encourage parents/guardians to visit or call the school based health center at any time. Per federal and state law, adolescent patients have the right to consent to reproductive and certain confidential services independently. Parents/Guardians may not have access to this information unless the patient consents.

☐ I consent to the sharing of information between the School Based Health Center and essential school personnel (school nurse, counselor, special education, speech therapist etc.) for treatment/medical purposes.

☐ I consent to photographs, video, digital or other images required to document care in the confidential medical record.

PERMISSION TO DISCLOSE TO FAMILY OR OTHER INDIVIDUALS:

Pediatric Consent

Non-parental consent: For pediatric patients under the age of 18, you may designate another person to attend visits and authorize treatment decisions.

- ☐ No, I do not give consent to others, only the patients parents/legal guardians will consent to treatment.
- ☐ Yes, I give consent for the following individual(s) (ie: step-parent, grandparent, friend) to attend appointments, give consent for services, and to make treatment decisions for my child in my absence. This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s)	Relationship to Student	Phone Number

FINANCE POLICY:

ConnexCare's School Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have **NO out-of-pocket costs**. However, if the student requires services that are not provided at the SBHC (x-rays, labs etc.), there may be out of pocket costs incurred.

☐ I authorize ConnexCare and its representatives to release any information they obtain, including medical information, to the insurance company to process claims for payment. In addition, I authorize the insurance company to pay ConnexCare for services rendered.

NOTICE OF PRIVACY PRACTICES/PATIENT BILL OF RIGHTS:

Our Notice of Privacy Practice 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, Non-Discrimination Notice, and Patient Bill of rights before signing this Consent Form or at any time by request. The most current Notice of Privacy Practices, Non-Discrimination Notice, and Patient Bill of Rights can be found on our Website at www.connexcare.org.

☐ I acknowledge that I have received/been made aware of our **Notice of Privacy Practices** and our **Patient Bill of Rights**.

☐ I would like the School Based Health Center to act as my child's Primary Care Provider.

☐ My child has a Primary Care Provider that they will continue to see. Name, City:

Name of Person completing this form

Signature

Date

ConnexxtCare Medical History Form

Student Name: _____ Date of Birth: _____

PREFERRED PHARMACY/HOSPITAL INFORMATION:

Name/Location of Pharmacy _____ Telephone # _____

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

PATIENT BIRTH HISTORY:

Birth Weight _____ Length _____ Place of Birth _____

☐ Yes ☐ No Any medical problems at birth? If yes, please list _____

PATIENT MEDICAL HISTORY:

Date of Last Physical Exam: _____

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

☐ Yes ☐ No Does your child have any environmental allergies? If yes, please list allergies: _____

Is your child taking any medications? ☐ Yes ☐ No If yes please list _____

Has your child had any of the following?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Colds (6 or more per year) | <input type="checkbox"/> Convulsions or Fainting |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> 3 Day Measles |
| <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Urinating Problems | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> 10 Day Measles |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Pneumonia |

☐ Yes ☐ No Serious Accidents _____

☐ Yes ☐ No Operations/Surgery _____

☐ Yes ☐ No Hospital Visits – Overnight _____

☐ Yes ☐ No Any other concerns about your child that you would like us to be aware of? _____

FAMILY HISTORY:

Have any family members had any of the following?

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recent Contagious Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Drinking Problem/Alcoholism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Developmental Disabled | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Drug Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Behavioral Health Issues | | |

Other, please explain _____

BEHAVIOR AND SCHOOL:

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

Does your child suffer from any of the following?

- | | | | | |
|--------------------------------------|---------------------------------------|---|--|--|
| <input type="checkbox"/> Fussiness | <input type="checkbox"/> Won't Mind | <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Can't Toilet Train | <input type="checkbox"/> Eats Dirt, Paint, or Glue |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Overactive | <input type="checkbox"/> Slow Learner | <input type="checkbox"/> Bad Temper |
| <input type="checkbox"/> Jealousy | <input type="checkbox"/> Holds Breath | <input type="checkbox"/> Miserable/ Withdrawn | <input type="checkbox"/> Doesn't Pay Attention | <input type="checkbox"/> Speech Problems |

Other, please explain _____

Name of Person completing this form

Signature

Date

ConnexCare Policies and Consents for School Based Health Center Dental Services

Student Name: _____ Date of Birth: _____

CONSENT FOR DENTAL SERVICES:

☐ I authorize my child to receive dental services provided by the staff of the ConnexCare School Based Health Center Program.

Services may include, but are not limited to the following:

- Dental screening and X-rays
- Prophylactic dental cleaning
- Dental sealants
- Fluoride treatments
- Referral to outside agencies for services not provided at the School Based Health Center

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☐ I consent to the sharing of information between the School Based Health Center and essential school personnel (school nurse, counselor, special education, speech therapist etc.) for treatment/medical purposes.

☐ I consent to photographs, video, digital or other images required to document care in the confidential medical record.

PERMISSION TO DISCLOSE TO FAMILY OR OTHER INDIVIDUALS:

Pediatric Consent

Non-parental consent: For pediatric patients under the age of 18, you may designate another person to attend visits and authorize treatment decisions.

- ☐ No, I do not give consent to others, only the patients parents/legal guardians will consent to treatment.
- ☐ Yes, I give consent for the following individual(s) (ie: step-parent, grandparent, friend) to attend appointments, give consent for services, and to make treatment decisions for my child in my absence. This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s)	Relationship to Student	Phone Number

FINANCE POLICY:

ConnexCare's School Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have **NO out-of-pocket costs**. However, if the student requires services that are not provided at the SBHC (outside x-rays, outside procedures etc.) there may be out of pocket costs incurred.

☐ I authorize ConnexCare and its representatives to release any information they obtain, including medical information, to the insurance company to process claims for payment. In addition, I authorize the insurance company to pay ConnexCare for services rendered.

NOTICE OF PRIVACY PRACTICES/PATIENT BILL OF RIGHTS:

Our Notice of Privacy Practice 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, Non-Discrimination Notice, and Patient Bill of rights before signing this Consent Form or at any time by request. The most current Notice of Privacy Practices, Non-Discrimination Notice, and Patient Bill of Rights can be found on our Website at www.connexcare.org.

☐ I acknowledge that I have received/been made aware of our **Notice of Privacy Practices** and our **Patient Bill of Rights**.

☐ My child does not have a Primary Dentist.

☐ My child has a Primary Dentist. Name, City:

Name of Person completing this form

Signature

Date

ConnexCare Dental History Form

Student Name: _____ Date of Birth: _____

PATIENT DENTAL HISTORY:

Date of last Dental Exam: _____ Date of Last Cleaning: _____

Does your child have a primary dentist? ☐ Yes ☐ No

Primary Dentist Name: _____

Address: _____

Phone: _____

Name/Location of Pharmacy: _____

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

Is your child taking any medications? ☐ Yes ☐ No _____

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

Any medical concerns you would like us to be aware of: ☐ Yes ☐ No _____

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

****The School-Based Health Center Dental Department will take annual x-rays, as needed, to diagnose decay (cavities) that may not be visible clinically.*

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

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

☐ I would like to be present for my child's dental appointments at the School-Based Health Center.

☐ I do **NOT** need to be present for my child's dental appointments at the School-Based Health Center.

Name of Person completing this form

Signature

Date

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