ConneXtCare™
A Community of Care

School Based Health Center Enrollment Form

*****Please indicate your enrolled school district and program choices*****

- ☐ **APW** Middle Senior High Medical
- ☐ **APW** Elementary Medical
- ☐ **APW** Elementary Dental
- ☐ **Sandy Creek** Medical
- ☐ **Sandy Creek** Dental
- ☐ **Mexico** Middle School Medical
- ☐ **Fairgrieve** Elementary Dental
- ☐ **Pulaski** Middle Senior High Medical
- ☐ **Lura Sharp** Elementary 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 ☐ 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: _____ 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 # _____

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

Date of Last Physical Exam: _____

Name of Pharmacy: _____ Telephone _____

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 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: _____

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: _____

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	□ 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: _____

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

CONNEXTCARE DENTAL ENROLLMENT:

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 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

☐ 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

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**.**