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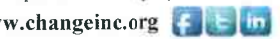
www.changeinc.org 

Please complete the Enrollment Form checklist and return to the School-Based Health Center.

Please check one:

☐ My child is an active patient at a School-Based Health Center or a Family Medical Care facility.

If so, which facility? ☐ FMC Newell ☐ FMC Weirton ☐ FMC Wintersville ☐ Weirton Elementary

☐ I am enrolling my child at the School-Based Health Center (***Please complete the checklist below***).

If enrolling, please complete these forms found in the packet per child:

- ☐ Medical Demographics Form
- ☐ Child Informed Consent
- ☐ Medical Health History Form
- ☐ Informed Consent for Behavioral Health / Therapy
- ☐ Dental Informed Consent
- ☐ Dental History and Consent Form

Student Name:____

Grade:____________ **Teacher:**____________________________

Parent/Guardian's Name: ________________________________

Phone Number: ______________________________________

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Medical Demographics Form

Patient Name:____
Last Name *First Name* *Middle Initial*

Address:____
 # Street Name *City* *State* *Zip Code*

County:________________ **Home Phone #:** ___________________**Cell Phone #:**________________________

Work Phone #:_______________________**E-Mail:**____

Preferred Method of Contact: □ Home Phone □ Cell Phone □ Work Phone □ Mail □ E-Mail

I would like to sign up to receive appointment reminders via cell phone text message: □ Yes □ No

Marital Status: □ M □ S □ W □ D Maiden Name (if applicable):________________**Gender:** □ F □ M

Social Security #:________/________/___________**Employed:** □ **Full-time** □ **Part-time** □ **Student**_________

Date of Birth:______/_______/_________ **City and State of Birth:**________________________________

Race:__________________ **Ethnicity:** □ Non-Hispanic □ Hispanic **Preferred Language:**________________

Agricultural Worker: □ Yes □ No **Veteran:** □Yes □ No

Housing Status: □ **Not Homeless** □ **Homeless Shelter** □ **Public Housing** *(Not Including Section 8)*
□ **Transitional** □**Other**____

Primary Care Provider:__________________________________**Pharmacy:**___________________________

Guardian Name(s) if patient is a minor:____

Relationship to Patient: □ Parent □ Grandparent □ Foster Parent □ Other ______________________

Primary Contact #:______________________________**Secondary Contact :**______________________

(Mark all that apply to above) □ Emergency Contact □ Primary Care Giver □ Legal Guardian □ Lives With

Name of Emergency Contact: (if different than above)____

Primary Emergency Contact #: (if different than above)____

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Child Informed Consent Form

I, ________________________________, the parent/guardian of ________________________________,
(Parent/Guardian's Name) (Minor's Name)

grant permission to utilize the medical, dental, and/or behavioral health services offered through the school-based health center.

Initialing each line and/or signing below, you acknowledge all of the following:

________ (Initial)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use your Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notice of Privacy Practices" provides a more complete description of permitted uses and disclosures.

________ (Initial)

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby authorize payment directly to CHANGE, Inc.'s Family Medical Care, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

________ (Initial)

PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES

I understand that the service I will be provided with via my Healthcare Provider or office staff may or may not be covered by my insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that CHANGE, Inc.'s Family Medical Care is not responsible to know whether my insurance will pay or require prior-authorization.
If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reasons unpaid, as well as all efforts are made to obtain payment from my insurance, I understand I am financially responsible for payment of the denied services.

________ (Initial)

ELECTRONIC RECORD TRANSFER

I understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so. I understand that if I need to transfer my medical records, that I am required to sign a separate Authorization to Release form with the Medical Records department. I absolve CHANGE, Inc.'s Family Medical Care, and its personnel of any liability relating to the transfer of said records.

________ (Initial)

AUTHORIZATION TO TREAT

I hereby authorize any provider employed as part of CHANGE, Inc.'s Family Medical Care Health Centers, to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself.

________ (Initial)

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

I hereby authorize CHANGE, Inc.'s Family Medical Care to exchange health and education records (including immunization records) with the appropriate school district for the purpose of providing care and treatment, if applicable.

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HIPAA RELEASE: **I hereby authorize CHANGE, Inc.'s Family Medical Care Health Centers, providers and/or staff to discuss my medical information with the following person(s); This does not allow the release of records to this person(s):**

Name — Relationship to Patient

Name — Relationship to Patient

Name — Relationship to Patient

Name — Relationship to Patient

Name — Relationship to Patient

Name — Relationship to Patient

Patient's/Guardian's Signature — **Date**

Relationship to Patient

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Medical Health History Form

Patient's Name: ______________________________ Birth Date:_____/_____/______

Patient's Family Doctor: ______________________________ Phone: (_____)_____-__________

Eye glasses? ☐ No ☐ Yes Exposed to second hand smoke? ☐ No ☐ Yes

List Medications taken on a daily basis:

Name: ______________________ mg________ Frequency:______________________

Name: ______________________ mg________ Frequency:______________________

Name: ______________________ mg________ Frequency:______________________

Please list any Chronic Health Problems, Previous Hospitalization, or Surgery:_________

____

____

____

Allergies (If yes, please list):

Food: ☐ No ☐ Yes If yes,______________________________

Medication: ☐ No ☐ Yes If yes,______________________________

Bees: ☐ No ☐ Yes If yes,______________________________

Any history of or difficulty with any of the following? (check if yes):

☐ AIDS/HIV
☐ Anemia
☐ Asthma
☐ Bed Wetting
☐ Birth Defects
☐ Bladder Problems
☐ Bleeding, Excessive
☐ Cancer
☐ Cerebral Palsy
☐ Chicken Pox
☐ Constipation/Diarrhea
☐ Convulsions
☐ Depression
☐ Diabetes
☐ Drugs/Alcohol
☐ Ear Infections
☐ Epilepsy
☐ Fainting
☐ Hearing Problems
☐ Heart Problems
☐ Hepatitis
☐ Kidney Disease
☐ Lead Poisoning
☐ Measles
☐ Mononucleosis
☐ Mumps
☐ Pneumonia
☐ Rheumatic Fever
☐ Sinus Problems
☐ Speech Problems
☐ Thyroid Disease
☐ Tuberculosis
☐ Urinary Disease
☐ Vision Problems
☐ Worms
☐ Other:__________________

Date of last Well Child Visit: ________________________

The information that I have provided is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status.

Parent/Guardian Signature: ______________________________ Date:______________

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All Information is confidential.

Date:_____________

Patient's Full Name:____ Grade: ______ Sex:______

Birth Date:______/______/_______ Social Security #: ______/______/_________ Race: ___________________

I authorize a physician assistant, physician, or designated health professional to provide necessary and/or advisable treatment for my child. I authorize release of written and verbal information relevant to my child's health care between the school nurse and the health center's staff only when necessary for his/her care. In case of emergency, every effort will be made by the health center staff to notify the parent/guardian. I understand the acknowledgement of Notice of Privacy Practices and know my minor child's rights as a patient of the school-based health center.

I authorize the school-based health center to release information regarding treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the CHANGE, Inc.'s Family Medical Care. I am financially responsible for non-covered services, but understand that services will not be denied due to inability to pay.

Guarantor Insurance:

Mother/Guardian: _________________________________ Birth Date:______/______/_______
Mother's SSN: ______/______/_________ Work #: (_____)_____-______ Cell #: (_____)_____-______

Father/Guardian: _________________________________ Birth Date:______/______/_______
Father's SSN: ______/______/_________ Work #: (_____)_____-______ Cell #: (_____)_____-______

Patient's Home Address: _________________________________ City:______________________ State: ______ Zip:__________
Patient's Home Phone #: (_____)_____-______
Guardian's Email Address:____

Name of Emergency Contact in case parent cannot be reached: ____
Relationship to Patient: ______________________________ Phone #: (_____)_____-______

Parent/Guardian Signature: ____ ***Date:*** _______________

Insurance Information: Please send a copy of the insurance/medical card (if possible).

Private Insurance

Name of Insurance Company: ____
Address: ____ City:____________________ State: _______ Zip:__________
Phone #: (_____)_____-______ Employer/Company Name: ____
Name of Insured Employee: _______________________________ Birth Date:____/____/_____ SSN: ____/____/______
Policy Number: ____________________________ Group Number: __________________________

	MEDICAID	*ID NUMBER*	
1.	☐ Straight West Virginia Medicaid	________________________	
2.	☐ Aetna Better Health	________________________	
3.	☐ Health Plan	________________________	
4.	☐ Unicare	________________________	
5.	☐ WV Family Health Plan	________________________	
6.	☐ WV CHIP	________________________	Co-Pay $_________
7.	☐ Straight Ohio Medicaid	________________________	
8.	☐ Buckeye Community Health Plan	________________________	
9.	☐ CareSource of Ohio	________________________	
10.	☐ Molina of Ohio	________________________	
11.	☐ Paramount	________________________	
12.	☐ United Healthcare of Ohio	________________________	

☐ No Insurance / Private Pay (A sliding fee scale is available for families that are uninsured. Charges are based on income and family size. A copy of the parent/guardian's proof of income must be on file with the application in order to be eligible). ***Please call our health benefits coordinator at 304-748-2828 or 740-314-8258.***

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INFORMED CONSENT FOR BEHAVIORAL HEALTH/THERAPY

This form documents that we, ______________________________ ("parents/guardian"), give our consent and agreement to ______________________ ("therapist") to provide therapeutic treatment to, ______________________ ("patient") and to include us, the parents, as necessary, in regards to the treatment.

While the parents can expect benefits from this treatment, they fully understand that no particular outcome can be guaranteed. The parents understand that they are free to discontinue treatment at any time, but that it would be best to discuss with the therapist any plans to end therapy before doing so.
The parents have fully discussed with the therapist what is involved in therapy and understand and agree to the policies about scheduling, fees and missed appointments. The discussion about therapy has included the therapist's evaluation of present problems, the method of treatment, goals and length of treatment, and information about record-keeping. The parents have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. The parents understand that therapy can sometimes cause upsetting feelings to emerge, and that problems may worsen temporarily before improving.

The therapist has told the parents whom to call if an emergency arises if the therapist is unavailable. Failure to follow through with therapist emergency recommendations may result in termination of services.

The parents have access to a copy of this form and a HIPAA Notice of Privacy Practices. A copy can be provided if the parents do not have access to the internet. The parents understand that information about therapy is almost always kept confidential by the therapist and not revealed to others besides the parents unless a parent authorizes such release. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The therapist is required by law to report suspected child abuse or neglect to the proper authorities.
2. If the therapist learns that he or she intends to harm another person, the therapist must try to protect the endangered person, including by telling the police, the person and other health care providers. Similarly, if self-harm is disclosed or health is in any immediate danger, the therapist will try to protect, including, as necessary, by telling the police and other health care providers, who may be able to assist.
3. If court proceedings are involved, the therapist may be required by law to reveal information about treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the therapist, civil commitment hearings, and court-ordered treatment.
4. If health insurance or managed care plan will be reimbursing or paying the therapist directly, they will require that confidentiality be waived and that the therapist give them information about the treatment.
5. The therapist may consult with other healthcare professionals about treatment, but in doing so, will not reveal any personal, identifiable information unless specific consent to do so is obtained from a parent. Further, when the therapist is away or unavailable, another therapist may answer calls and will need to have access to information about the treatment.
6. If an account with the therapist becomes overdue and responsible parties do not work out a payment plan, the therapist will have to reveal a limited amount of information about a patient's treatment in taking legal measures to be paid. This would include the names, social security number, address, dates and type of treatment and the amount due.

In all the situations described above, the therapist will try to discuss the situation with a parent before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

The parents/legal guardians have rights to general information about the therapy such progress, information about any dangers present (self or others), and, upon request, copies of the treatment records (with certain qualifications and exceptions). The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust

between patient and therapist, especially for adolescents over the age of 12.

The parents agree that in the event of custody or visitation hearings regarding any legal proceedings, each of the parents and their attorneys will not require the therapist to testify as any such action could interfere with the treatment provided. If such a proceeding does occur, a mental health professional will be appointed to perform such an evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding. Written information regarding, and/or the record of treatment will only be provided as required by law or upon the authorization of either parent.

Children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the therapist. If both parents are consenting to therapy:

- Each of us agrees that he or she will not end the therapy without the agreement of the other parent, and that if we disagree about the continuation of therapy, we will try to come to an agreement, by counseling if necessary, before ending therapy.
- We each agree to cooperate with the treatment plan. We understand that without mutual cooperation, the therapist may not be able to act in the best interests and may have to end therapy.
- We agree that each of us has, and shall continue to have, the right to be informed about the progress of treatment and have access to the treatment records of the therapist. We further agree that the therapist may release information or records to either of us without any additional authorization of the other.

If participating in a managed care plan, the parents have discussed with the therapist their financial responsibility for co-payments and the plan's limits on the number of therapy sessions. If the parents are not participating in a managed care program, they understand that they are fully, financially responsible for treatment including any portion of the fees not reimbursed by health insurance. The therapist has also discussed options for continuation of treatment when managed care or health insurance benefits end. If uninsured, the parent will be informed of the sliding fee scale discount program available through CHANGE, Inc.

The parents understand that they have a right to ask the therapist about the therapist's training and qualifications and about where to file complaints about the therapist's professional conduct.

By signing below, the parents/legal guardians are indicating that they have read and understood this agreement, that they give consent to the therapist's treatment, and that they have the proper legal status to give consent for therapy.

______________________________ ______________
Signature of Parent/Legal Guardian Date

______________________________ ______________
Signature of Parent/Legal Guardian Date

______________________________ ______________
Signature of Patient (over 12 Years of Age) Date

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DENTAL INFORMED CONSENT

Patient's Name: ______________________________

The form is to obtain your consent for dental treatment. Please read this form carefully and ask us about anything that you do not understand. Our dentist, dental hygienist, or the dental staff will be pleased to explain it. Thank you.

Below is a list of dental procedures that may be performed on your child:

1. **Diagnostic Procedures:** Radiographs (X-rays), photographs of the teeth and jaws, and Caries Risk Assessment.

2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth using hand instruments and ultra-sonic scalers, and teeth polishing with special toothpaste.

3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay. No eating or drinking thirty minutes after application.

4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.

5. **Local Anesthesia:** Anesthesia is administered prior to a procedure to help dull pain. The most common form is local anesthesia, meaning that it dulls pain in all or part of the mouth during dental work, but does not cause the patient to go to sleep. It usually wears off two to three hours after the procedure and is most often used when a patient is getting a filling or extraction.

6. **Fillings and Repairs:** Dental fillings and repairs use restorative materials used to repair teeth which have been compromised due to cavities or trauma. A filling helps to restore a tooth damaged by decay back to its normal function and shape, and helps prevent further decay by eliminating areas where bacteria can enter the tooth. Your dentist will consider a number of factors when choose which type of filing material is best for the patient.

7. **Extractions:** A severely damaged tooth may need to be extracted.

Please note that additional procedures may need to be completed by a pediatric dentist.

I understand that all dental procedures have associated risks and I acknowledge giving my consent for treatment listed above.

______________________________ ______________________________

(Patient or Parent/Guardian's Signature) Date

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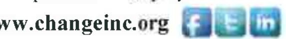
www.changeinc.org 

Dental History and Consent Form

General Information

Patient's Name: ______________________ Date of Birth: ____________ SSN: ____________

Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Parent/Guardian: ______________________ Email: ______________________

Home Phone: ______________________ Cell Phone: ______________________

School: ______________ Grade: ________ Teacher's Name: ______________________

Sex: ☐ Male ☐ Female Race/Ethnicity (*Check all that apply*): ☐ American Indian/Alaskan Native ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander

Health & Dental Information

Patient's Physician: ______________________ Patient's Dentist: ______________________

Is a serious health problem present? ☐ Yes ☐ No
If yes, please explain: ____

Asthma? ☐ Yes ☐ No

History of rheumatic fever or rheumatic heart disease? ☐ Yes ☐ No

Are antibiotics required before dental care? ☐ Yes ☐ No

Currently taking any medications? ☐ Yes ☐ No
If yes, please list: ____

Allergic to any medication? ☐ Yes ☐ No
If yes, please list: ____

Allergic to latex? ☐ Yes ☐ No

Date of last dental exam: ______________________
What was the reason for the visit? ____

During the last 12 months, was there any time dental care was needed, but unable to receive dental services?
☐ Yes ☐ No

If yes, why (check all that apply)?
☐ Could not afford it.
☐ No transportation.
☐ Dentist did not take Medicaid/Insurance
☐ Not serious enough problem.
☐ Difficulty getting an appointment.
☐ Do not know/Do not remember.
☐ No insurance.
☐ Do not have a dentist.
☐ Other: ______________________

(over...)

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Dental History and Consent Form *(continued)*

Payment Information

Please provide the following billing information along with a copy of your insurance card:

MEDICAID/CHIP

Patient's Name: ____________________

Policy Holder ID # / SSN: ____________________ Plan/Group #: ____________________

DENTAL INSURANCE

Name of Insurance Company: ____________________

Address of Insurance Company: ____________________

Name of Policy Holder: ____________________

Policy Holder ID # / SSN: ____________________ Plan/Group #: ____________________

Employer Name: ____________________

Consent for Treatment and Billing: Signature Required

In general, any information that is about your health, the care and treatment you receive or the payment for care and treatment is considered protected health information (PHI) and protected by the School-Based Health Center Program.

Your signature below gives permission for the School-Based Health Center, a division of CHANGE, Inc., to share the results of the dental exam with the appropriate State Health and Human Resources and the State Department of Education.

Your signature below indicates that you are the parent or legal guardian of the patient whose name appears on the application. By signing below, you understand that participating in the program is voluntary and hereby agree to release and discharge all parties involved, including without limitation the dental professionals who are conducting the examinations or screenings, from any and all liabilities, suits, costs or expenses in any way relating to the treatment provided.

Your signature below indicates that you are the patient's parent or legal guardian and give consent for dental examination or screening, cleaning, fluoride, sealants, x-rays, and any necessary dental procedures to correct the dental and oral defects as prescribed.

Signature of Parent/Guardian: ____________________ **Date:** ____________________