SCHOOL BASED HEALTH CLINIC
PATIENT INFORMATION AND CONSENT FORM

Date___________________

As a Federally Qualified Health Center, we are required by the Bureau of Primary Health Care to collect data on all our patients

Please choose which services you want for your child to receive

☐ **Dental _____ Initial** ☐ **Medical _____ Initial** ☐ **Behavioral Health_______ Initial**

PLEASE PRINT

PATIENT NAME____ Sex: ☐Male ☐Female
Last First Middle

Date of Birth______________________ Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

Mailing Address____

City_____________________________________ State_____________ Zip______________

Physical Address (if different)_______________________________ County of Residence___________

City_____________________________________ State_____________ Zip______________

Home Phone___________________________ Cell/Alternate Phone______________________

Primary E-mail Address______________________________ Do you use the Patient Portal: ☐Yes ☐No

Legal Guardian (if patient is 17 or under) ____

Name of Secondary Contact___________________________ Secondary Contact Phone______________

(family, friend or neighbor, not living with you, who can get a message to you)

Relationship to Secondary Contact_____________________________

Preferred Pharmacy_____________________________ Location_________________________

Preferred Lab_______________________________________

Primary Physician_________________________ ☐ May Contact Phone # ______________________

Preferred method of communication: ☐Phone/Cell ☐ Email ☐Text ☐Patient Portal ☐ Letter (check all that apply)

Employed? ☐ Full Time ☐ Part-time ☐ No Employer:_____________________________________

Agricultural Worker: ☐No ☐Migrant Veteran: ☐ Yes ☐ No ☐ N/A (17 or under)

Student? ☐ Full Time ☐ Part-time ☐ No School District:_________________________________

Highest Education Level: ___________________________

Preferred Language: ☐English ☐Spanish ☐Other_________________________(indicate which language)

Language assistance. If you need such assistance, please check what kind of assistance you require.

☐ Sign Language ☐ Visual Aides

Ethnicity:

☐Hispanic/Latino ☐Not Hispanic/Latino

CCHC does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance status or criminal record.

Race: Please check ALL that apply: ☐ White ☐ Black/African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Decline to Answer

Housing Status:
☐ Not Homeless ☐ Homeless (without permanent housing)

ANNUAL INCOME: Please circle family size and applicable income level

Family Size	A	B	C	D	E	Over
1	$0-$12,140	$12,141-$15,175	$15,176-$18,210	$18,211-$21,245	$21,246-$24,280	$24,281 & Up
2	$0-$16,460	$16,461-$20,575	$20,576-$24,690	$24,691-$28,805	$28,806-$32,920	$32,921 & Up
3	$0-$20,780	$20,781-$25,975	$25,976-$31,170	$31,171-$36,365	$36,366-$41,560	$41,561 & Up
4	$0-$25,100	$25,101-$31,375	$31,376-$37,650	$37,651-$43,925	$43,926-$50,200	$50,201 & Up
5	$0-$29,420	$29,421-$36,775	$36,776-$44,130	$44,131-$51,485	$51,486-$58,840	$58,841 & Up
6	$0-$33,740	$33,741-$42,175	$42,176-$50,610	$50,611-$59,045	$59,046-$67,480	$67,481 & Up
7	$0-$38,060	$38,061-$47,575	$47,576-$57,090	$57,091-$66,605	$66,606-$76,120	$76,121 & Up
8	$0-$42,380	$42,381-$52,975	$52,976-$63,570	$63,571-$74,165	$74,166-$84,760	$84,760 & Up

MEDICAL HISTORY- DENTAL PATIENTS ONLY

Asthma	☐ Yes ☐ No	Recent Toothache	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
Seizures/Epilepsy	☐ Yes ☐ No	Rheumatic Heart Disease	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No
Latex Allergy	☐ Yes ☐ No	Other	☐ Yes ☐

Any Surgeries / Other / Explain:____

Does your child have any allergies? ☐ Yes ☐ No

If yes, please explain: ____

List any medications your child is taking: ____

INSURANCE

☐ HealthCareUSA ☐ MissouriCare ☐ Homestate Health ☐ MoHealthNET ☐ Uninsured ☐ Other (Commercial)

Enter Child's Insurance ID Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Primary Medical Insurance:____

CONSENT FOR DIAGNOSTIC AND PREVENTIVE TREATMENT & ASSIGNMENT OF BENEFITS

CONSENT FOR MEDICAL, DIAGNOSTIC AND PREVENTIVE TREATMENT & ASSIGNMENT OF BENEFITS

***Dental Services**- I/We hereby give my/our permission for my/our child to participate in COMTREA's Mobile Access and Prevention Clinic. I/We allow my/our child to receive local anesthetic (numbing of the teeth), preventive and restorative dental treatment (including but not limited to sealants, cleaning and fluoride, dental radiography and clinical photography).*

***Medical Services**- I/We hereby give my/our permission for my/our child to participate in COMTREA's Medical School Based Clinic. I/We allow my/our child to receive routine treatment/services regarding the necessary and/or routine treatment including but not limited to physical exam (general, sports or pre-employment), immunization, laboratory services, assistance with chronic illness, prescription and over-the-counter medications and acute illness.*

I/We understand that eligible services may be billed to Medicaid and/or private insurance. I hereby instruct and direct all proceeds of insurance to be paid to COMTREA Inc. to be paid my check for the dental and/or medical expense benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for the professional services rendered. I authorize COMTREA Inc. to release or receive information on eligibility and/or benefit information for the purpose of filing insurance claims. I also understand that additional information may be needed from my file to achieve maximum benefits. My signature will be kept on file for the filing of future insurance claims. I understand this consent may be revoked at any time upon my request. Further, I/We as the applicant's parent (s) or guardian (s) authorize COMTREA or individuals designated by COMTREA to act for me/us in an emergency, accident or illness. I/We acknowledge the receipt of the HIPAA Notice of Privacy Practice on the back of this consent form.

I/We would like for my/our child to receive the following services (check all that apply):

____ Dental ____ Medical

______________________________ ***Signature of Parent/Guardian*** *Date* _____________ __________________________***Signature of Witness*** *Date* _____________

Other proposed change would be under the insurance

Primary Medical Insurance ___________________ *ID Number* _____________________ *Policy Holder Name* ____________________

FMTRT0045-School
Revised 3/26/18

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Full Notice of Privacy Practices available upon request or at www.COMTREA.org

PLEASE REVIEW IT CAREFULLY. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Under the Omnibus Rule, your authorization is required for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI. Your authorization is required for most uses and disclosures of psychotherapy notes. Any other uses and disclosures not described in this NPP will be made only with authorization from the individual to whom the PHI relates. You have the right to opt out of receiving such communications regarding Fundraising communications to raise funds for agency programs. You have the right, if you pay out-of-pocket in full for a healthcare item or service, to restrict disclosures of PHI to your health plan.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 636 321-0114

Required by Law: We may use or disclose your health information when we are required to do so by law.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your medical information to military authorities of Armed Forces or foreign military personnel under certain circumstances; to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities, and to protect the president; and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading, a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer, Phone: 636 321-0114 or 636 931-2700 ext 1047, Email: hipaaofficer@comtrea.org, Effective Date: April 1, 2016