



# InterCommunity

Health Care for the Whole Person

## InterCommunity School Based Health Centers Registration and Consent Form

School Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Dear Parent or Guardian: Our School Based Health Center is pleased to provide medical and behavioral health services at your child's school during school hours. Please fill out this form and return it to the school with your child to enroll in the program.**

Student Information

Last Name		First Name		MI	Date of Birth	
Street Address			City	State	Zip	Social Security Number
<input type="checkbox"/> Public Housing <input type="checkbox"/> Homeless: If yes, please specify: <input type="checkbox"/> Shelter <input type="checkbox"/> Doubling up <input type="checkbox"/> Transitional <input type="checkbox"/> Other						
Home Phone	Cell Phone	Work Phone	Email Address	Emergency Contact Person	Emergency Contact Number	
<b>Sex</b>	<b>Language</b>		<b>Ethnicity</b>	<b>Race</b>		
<input type="checkbox"/> M	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> F	<input type="checkbox"/> Spanish	<input type="checkbox"/> Indian	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> American Indian/Alaskan Native		
	<input type="checkbox"/> Russian	<input type="checkbox"/> Other		<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Other Pacific Native	
				<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other	
				<input type="checkbox"/> Unreported or refuse to report		
Parent/Guardian Name _____				Parent/Guardian Date of Birth _____		

Insurance Information

Primary Medical Insurance	Insurance ID/Medicaid ID #	Group #
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's Social Security #

Income

My Annual Household Income is: \_\_\_\_\_ Total # of Dependents in Household (including patient): \_\_\_\_\_

I give permission for my child to receive medical and behavioral health treatment/services by InterCommunity School Based Health Centers. I understand that this authorization is valid as long as my child is enrolled in the East Hartford School District or until I revoke this authorization with the Program Coordinator at InterCommunity School Based Health Centers.

I hereby authorize InterCommunity to use and disclose my child's protected health information (including both physical and mental health information) for treatment, payment and healthcare operation purposes, including the release of such information to process claims to my insurance company. I authorize direct payment from my insurance company to InterCommunity.

In the event that trained school personnel, such as school nurses or health aides, are not available to give prescribed medications taken routinely at school, I authorize InterCommunity staff to administer such medications to my child.

I consent to receiving phone calls regarding services my child receives or may be eligible to receive and agree to receive a copy of InterCommunity's Notice of Privacy Practices via email at the email address listed above. The Notice of Privacy Practices can also be accessed at [www.intercommunityct.org/privacy-practices/](http://www.intercommunityct.org/privacy-practices/).

By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I have read, understand, and agree with each of the above paragraphs and certify that all of the information provided is true and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify and attest that all of the above information is true and correct. I understand that InterCommunity may verify information on this form. I understand that the financial information will determine eligibility for the Center's sliding fee discount. I also understand that if I intentionally misrepresent my family's income, my child will not be eligible to receive services at a discounted rate. I understand that if my child is uninsured, my fee will be based on a sliding fee schedule. I also understand that I will be financially responsible for all charges incurred.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Any protected health information released by InterCommunity that includes information that is protected by special state or federal laws, such as substance abuse treatment and HIV-related information, will be released in accordance with those laws. Please refer to InterCommunity's Notice of Privacy Practices, accessible at [www.intercommunityct.org/privacy-practices/](http://www.intercommunityct.org/privacy-practices/), for more information. InterCommunity's Notice of Privacy Practices also explains InterCommunity's ability to make your child's protected health information available to other providers through the Care Everywhere feature. Please contact InterCommunity's Privacy Officer at 860-569-5900 or [compliance@intercommunityct.org](mailto:compliance@intercommunityct.org) to learn how to opt in to this convenient way to share your child's information with other providers.

New Patient     Established Patient    Today's Date: \_\_\_\_\_

Parent(s) Name \_\_\_\_\_

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

Child's Doctor \_\_\_\_\_

Child's Medical History     Unknown     No Significant Medical History

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medicines:**

\_\_\_\_\_  
\_\_\_\_\_

**Reaction:**

\_\_\_\_\_  
\_\_\_\_\_

**This child has been DIAGNOSED with:**

- ADD/ADHD                      Age: \_\_\_\_\_
- Allergies/Hayfever              Age: \_\_\_\_\_
- Anemia                              Age: \_\_\_\_\_
- Asthma                              Age: \_\_\_\_\_
- Autism                              Age: \_\_\_\_\_
- Bipolar Disorder                Age: \_\_\_\_\_
- Bleeding/Blood Disorder      Age: \_\_\_\_\_
- Broken Bones - Details below: \_\_\_\_\_ Age: \_\_\_\_\_
- Cancer - Type: \_\_\_\_\_ Age: \_\_\_\_\_
- Celiac Disease                    Age: \_\_\_\_\_
- Chicken Pox                      Age: \_\_\_\_\_
- Constipation                      Age: \_\_\_\_\_
- Depression                        Age: \_\_\_\_\_
- Developmental Delay          Age: \_\_\_\_\_
- Diabetes                            Age: \_\_\_\_\_
- Frequent Ear Infections        Age: \_\_\_\_\_
- Stomach/Bowel Disorder        Age: \_\_\_\_\_
- Headaches/Migraines          Age: \_\_\_\_\_
- Heart Conditions                Age: \_\_\_\_\_
- Infectious Diseases              Age: \_\_\_\_\_
- Learning Disability              Age: \_\_\_\_\_
- Pneumonia                        Age: \_\_\_\_\_
- Scoliosis (curved spine)        Age: \_\_\_\_\_
- Seizures/Epilepsy                Age: \_\_\_\_\_
- Sickle Cell Anemia                Age: \_\_\_\_\_
- Stomach Problems                Age: \_\_\_\_\_
- Skin Issues                        Age: \_\_\_\_\_
- UTI/Bladder Infections        Age: \_\_\_\_\_
- Other \_\_\_\_\_ Age: \_\_\_\_\_

**Child's SURGERIES:**     None

- Appendectomy                    Age: \_\_\_\_\_
- Adenoidectomy                  Age: \_\_\_\_\_
- Ear Tubes                        Age: \_\_\_\_\_
- Other \_\_\_\_\_ Age: \_\_\_\_\_
- Other \_\_\_\_\_ Age: \_\_\_\_\_
- Eye Surgery                      Age: \_\_\_\_\_
- Hernia Repair                    Age: \_\_\_\_\_
- Tonsillectomy                    Age: \_\_\_\_\_

**Child's HOSPITALIZATIONS:**

- Hospitalization \_\_\_\_\_ Age: \_\_\_\_\_
- Hospitalization \_\_\_\_\_ Age: \_\_\_\_\_
- Hospitalization \_\_\_\_\_ Age: \_\_\_\_\_

**Child's FAMILY HISTORY:** Check the diagnoses given to the child's relatives     Unknown

**Please circle relationship:**

**M=**Mother, **F=**Father, **S=**Siblings, **GM=**Grandmother, **GF=**Grandfather, **O=**Other

Diagnosis of Relative	Relationship to child	Diagnosis of Relative	Relationship to child
<input type="checkbox"/> ADD	M F S GM GF O	<input type="checkbox"/> High Blood Pressure	M F S GM GF O
<input type="checkbox"/> Allergies	M F S GM GF O	<input type="checkbox"/> High Cholesterol	M F S GM GF O
<input type="checkbox"/> Anemia	M F S GM GF O	<input type="checkbox"/> Learning Disability	M F S GM GF O
<input type="checkbox"/> Asthma	M F S GM GF O	<input type="checkbox"/> Mental Retardation	M F S GM GF O
<input type="checkbox"/> Autism	M F S GM GF O	<input type="checkbox"/> Psychiatric Illness	M F S GM GF O
<input type="checkbox"/> Blood Disorder/ Sickle Cell	M F S GM GF O	(Depression, Addiction, etc.)	
<input type="checkbox"/> Cancer	M F S GM GF O	<input type="checkbox"/> Seizures/Epilepsy	M F S GM GF O
<input type="checkbox"/> Celiac Disease	M F S GM GF O	<input type="checkbox"/> SIDS (crib death)	M F S GM GF O
<input type="checkbox"/> Diabetes	M F S GM GF O	<input type="checkbox"/> Stroke before age 55	M F S GM GF O
<input type="checkbox"/> Stomach/Bowel Disorder	M F S GM GF O	<input type="checkbox"/> Sudden Death before age 55	M F S GM GF O
<input type="checkbox"/> Heart Disease before age 55	M F S GM GF O	<input type="checkbox"/> Other _____	M F S GM GF O

**Social/Environmental**

Child lives with:

- Parent(s):     Together     Apart
- Mother
- Father
- Relative \_\_\_\_\_
- Other \_\_\_\_\_

Adopted

- Smokers live in home with child?     Yes     No
- Child attends day care?                 Yes     No
- Pets in the home?                         Yes     No
- Well water?                                 Yes     No
- Home built before 1960?                 Yes     No

Other \_\_\_\_\_

**Complete below section if child is less than five years old or if there was a significant/complicated pregnancy history.**

**Pregnancy/Birth History:** Check all that apply

- Month prenatal care began \_\_\_\_\_
- Weeks of pregnancy \_\_\_\_\_
- Birth weight \_\_\_\_\_
- C-section
- Vaginal

**Pregnancy Complications**

- Infections     Diabetes     Pre-eclampsia
- Multiple Births
- Other \_\_\_\_\_

**Birth/Newborn Complications**

- Premature? How early? \_\_\_\_\_
- NICU stay? How long? \_\_\_\_\_
- Other \_\_\_\_\_

**Medications** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**During pregnancy, the child's mother:**

- Smoked? How much? \_\_\_\_\_
- Drank alcohol? How much? \_\_\_\_\_





**Notice of Patient Rights and Responsibilities  
Informed Consent/Permission to Treat/  
Consent to Uses and Disclosures for Treatment,  
Payment, and Health Care Operations Purposes/  
Acknowledgement of Privacy Practices**

- If I am incapable of consenting to, or authorizing, any of the foregoing under applicable law, my authorized representative (e.g., parent, legal guardian, or conservator) must indicate their consent/authorization to the foregoing on my behalf by signing below.

\_\_\_\_\_  
Print Name of Client/Patient    Date of Birth    Signature    Date

\_\_\_\_\_  
Print Name of Client's Representative    Representative's Signature    Date

\_\_\_\_\_  
Relationship/Legal Authority to the Client (i.e. parent/guardian/conservator of person)

**MINORS MUST ALSO SIGN IF THE FOREGOING RELATES TO THE USE OR DISCLOSURE OF  
SUBSTANCE USE DISORDER INFORMATION:**

Signature of Minor/Client: \_\_\_\_\_ Date: \_\_\_\_\_

**ADMINISTRATIVE USE ONLY**

Unable to obtain written consent because:  Individual Refused  Emergency treatment situation  Individual not able to sign due to incompetence/medical reason  Other: \_\_\_\_\_

Rights and Responsibilities reviewed and given to client.

Staff Signature & Date: \_\_\_\_\_



**Notice of Patient Rights and Responsibilities  
Informed Consent/Permission to Treat/  
Consent to Uses and Disclosures for Treatment,  
Payment, and Health Care Operations Purposes/  
Acknowledgement of Privacy Practices**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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

Please note that InterCommunity's Notice of Privacy Practices is subject to change. A copy of the most recent version can be found at the front desk or on InterCommunity's website at: <https://www.intercommunityct.org/>.

\_\_\_\_\_  
Print Name of Client/Patient      Date of Birth      Signature      Date

\_\_\_\_\_  
Print Name of Client's Representative      Representative's Signature      Date

\_\_\_\_\_  
Relationship/Legal Authority to the Client (i.e. parent/guardian/conservator of person)

**ADMINISTRATIVE USE ONLY**

Unable to obtain written consent because:  Individual Refused  Emergency treatment situation  Individual not able to sign due to incompetence/medical reason  Other: \_\_\_\_\_

Staff Signature & Date: \_\_\_\_\_

Sliding Fee Scale Application

Intercommunity's services are supported by state, federal and private grants that allow us to charge less than private providers. Still, patient fees are our main source of revenue. Please complete the following questions so we can best determine your fee scale level and charge you appropriately.

*If you choose not to answer the questions about your income, we will not be able to discount your services, and you will be responsible for full price payment today.*

*[ ] I decline to complete the below information and understand I will be charged full price for my services.*

Do you have health insurance? [ ] yes [ ] no, if yes what is the name of your plan,

Name of Plan \_\_\_\_\_

ID# \_\_\_\_\_

If no would you like to apply for health insurance? [ ] yes [ ] no

Do you receive SNAP benefits? [ ] yes [ ] no

If no, would you like to apply for SNAP (food stamps)? [ ] yes [ ] no

Are you under 18? [ ] yes [ ] no

**Financial Information**

[ ] I support myself, my weekly income is \$ \_\_\_\_\_ or

I work \_\_\_\_\_ hours each week at a rate of \$ \_\_\_\_\_ per hour.

[ ] My Family helps support me

Our total weekly income is \$ \_\_\_\_\_

How many people does this income support? \_\_\_\_\_

[ ] My partner or Spouse helps support me

Our total weekly income is \$ \_\_\_\_\_

How many people does this income support \_\_\_\_\_?

**Data collection**

All questions are confidential and are used for the statistical purposes only.

What is your primary language \_\_\_\_\_?

Race *Circle all that apply* BLACK WHITE

NATIVE AMERICAN/ALASKAN ASIAN HAWAIIAN/PACIFIC ISLANDER

LATINO/ [ ] YES [ ] NO

Veteran Status [ ] ACTIVE [ ] NOT ACTIVE [ ] NOT APPLICABLE

I, \_\_\_\_\_, self-attest that all the information provided regarding my income and family size is true.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient was educated surrounding our sliding fee scale and has refused to complete the required information.

Staff verification \_\_\_\_\_

Date completed \_\_\_\_\_

**\*Financial form must be completed by patients every year to qualify for sliding fee scale discount.**