



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	
Sex	Language		Ethnicity	Race		
<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 Manchester 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/.

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/, 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 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: _____

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.***