School-Based Health Center Enrollment and Consent Form

For office use only:
☐ Bangor ☐ Brewer ☐ RSU 34

Student Name____ Date of Birth________________________

General Consent for Care and Treatment Consent

I give consent for the above-named student to receive health care services provided by the school-based health center, including primary and preventive health care, mental health counseling, health screenings, comprehensive and sports physicals, acute care for minor illness and injury, immunizations, prescription medication and care of chronic conditions.

I understand that as an enrolled patient my child may be scheduled for an annual appointment with the clinic to administer a standardized health screening. My insurance may be charged for this visit, but I will not be responsible for any out-of-pocket expenses.

I understand that I may withdraw this consent at any time, either orally or in writing, by notifying PCHC in the manner described in PCHC's Notice of Privacy Practices. Otherwise, it will apply for the duration of my child's enrollment in the school district.

By signing below, I authorize all designated health center staff to provide necessary examinations, tests, evaluations, management, and treatment of my child's health care in accordance with applicable laws. I understand that I have the right to refuse any procedure or treatment.

In case of accident or serious illness, I request the school clinic to contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements are deemed necessary.

I understand that under Maine State Law, my child may consent for certain health care services without parental permission and unless failure to notify parent or guardian would seriously jeopardize the health of the minor, the practitioner will honor the confidentiality of the student.

Responsibility for Payment and Assignment of Benefits

I understand that I am responsible for paying all costs associated with services provided to my child by the SBHC. I understand PCHC may bill my insurance (including Medicaid) or other third parties for these services. I authorize and assign payment of benefits directly to Penobscot Community Health Care for services rendered. If I have insurance, I understand that all costs and fees not covered by insurance will be my responsibility.

HIPAA and Notice of Privacy Practices

I understand that PCHC must keep health information confidential, but may use and disclose health information for treatment, payment, or healthcare operations. I understand that a detailed list of allowed uses and disclosures is included in PCHC's Notice of Privacy Practices. For your convenience, a copy of our Notice of Privacy Practices is available on our website www.PCHC.com. To request a paper copy, please call (207) 992-9200 ext. 1297.

I understand that records and information may be exchanged between School-Based Health Center staff and my child's school with my authorization or when otherwise permitted by law without my authorization.

I understand the School-Based Health Center, my child's medical, dental and mental health care providers, and the school nurse may exchange information about my child in order to provide treatment. I authorize any referral to my child's primary care provider for health care that cannot be provided on site.

I understand the School-Based Health Center may release information regarding treatment to third-party payers or others for the purpose of billing or for any reason that may be required to comply with the statutes or regulations in accordance with accepted medical practice.

☐ **I have received a copy of Penobscot Community Health Care's Notice of Privacy Practices.**

I acknowledge that I have read the information described above and agree to enroll my child in the school-based health center (SBHC) at this time. I understand and agree to all the above statements. All my questions have been answered to my satisfaction, but I understand that I may call the SBHC if I have questions before or after I sign this form.

______________________________	________________________	__________
***Signature of Parent/Legal Guardian**	**Print Name**	**Date**

**Student will sign in place of parent/guardian when student is 18 or older or as permitted by law.*

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Student Name________________________________ Date of birth______________

School District ______________________________ Grade_______ Year of Graduation__________

Student Physical Address____

Student Cell # (HS students only) ____________________ ☐*OK to text routine appointment reminders to this number

**By default, text reminders go to the first parent/guardian listed below. Checking the box allows us to send to your student instead.*

Name of PCP______________________________ ☐ My child does not have a primary care provider

PCP Phone______________ Date of Last Physical______________ ☐ I'd like to use the SBHC provider as my child's PCP

Parent/Legal Guardian Information

Relationship to patient____________________Name______________________________

*Phone________________ Alt. Phone______________Email______________________

Relationship to patient____________________Name______________________________

Phone________________ Email____

Guarantor Information

Guarantor *(person financially responsible)*____________________________________

Relationship________________Phone______________Date of Birth__________SSN______________

Billing Address____

Insurance Information

Primary Insurance Information Insurance Company__________________________________

Address *(from back of ID card)*______________________________________Phone______________

Subscriber Name *(insured parent/guardian)*______________________________Date of birth__________

Subscriber SSN________________Policy #/Subscriber ID______________________Group Number__________

Secondary Insurance Information Insurance Company__________________________________

Address *(from back of ID card)*______________________________________Phone______________

Subscriber Name *(insured parent/guardian)*______________________________Date of birth__________

Subscriber SSN________________Policy/Subscriber ID______________________Group Number__________

MaineCare (Medicaid)

Member ID#__________________ Member Name *(as printed on card)*______________________________

☐ **No Insurance**

PCHC offers a Sliding Fee Program (based on household size and income), which reduces the cost of most services for those who qualify. Contact the SBHC for more information or go online to www.pchc.com/affordable-care/

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Student Name____Date of Birth____________________

Additional Information (Required)

As a federally qualified health center (FQHC), PCHC is required to collect the following information for each patient we serve. All information is confidential.

Primary language ☐ English ☐ French ☐ Spanish ☐ Sign Language ☐ Other

Race
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian/Chamorro ☐ Samoan ☐ Black/African American
☐ American Indian/Alaska Native ☐ White/Caucasian ☐ More than one race ☐ Other

Hispanic/Latino ☐ No ☐ Yes **If Yes**: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino

Sexual Orientation ☐ Straight/Heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Something else/other ☐ Unknown ☐ Choose not to disclose

Gender at Birth ☐ Male ☐ Female

Gender Identity ☐ Male ☐ Female ☐ Gender queer/questioning ☐ Transgender Male (female to male) ☐ Transgender Female (male to female) ☐ Other ☐ Unknown ☐ Choose not to disclose

Number of people living in your household? ________

Housing Status ☐ Not homeless ☐ Homeless ☐ Public housing ☐ Transitional ☐ Permanent Supportive Housing ☐ Unknown

If homeless, where are you staying? ☐ Shelter ☐ Doubled Up ☐ Street ☐ Other

Agricultural Worker (or dependent of) ☐ Yes ☐ No **If Yes, which one?** ☐ Migrant ☐ Seasonal

Military Veteran ☐ Yes ☐ No

Household income
☐ $0-$15,000 ☐ $15,001-$22,000 ☐ $22,001-$30,000 ☐ $30,001-$40,000 ☐ $40,001-$50,000 ☐ >$50,000

Penobscot Community Health Care Medical Records P.O. Box 439 Bangor, ME 04402-0439 Phone: (207) 404-8101 Fax: (207) 990-1248 Email: PCHCMR@pchc.com	**Patient Name:** **Patient's Former Name or Alias:** **Patient Address:** **Date of Birth:** **Patient's Phone Number:**

Authorization to Disclose Health Information

By signing below, I authorize Penobscot Community Health Care (PCHC) and its staff (*check applicable box(es)*):

☐ To **DISCLOSE** my health information below **TO**: ***AND/OR*** ☐ To **OBTAIN** my health information below **FROM**:

Name of Person or Organization: ______________________________

City/State/Zip Code: ______________________________

Phone:______________________________ Fax: ______________________________

By: ☐ Mail* ☐ Fax ☐ Email** (*specify recipient's email address*: ______________________________)

☐ Verbal Communication ☐ other (*specify instructions*): ______________________________

** Records provided by mail will be sent on a compact disc, unless you specify other instructions.*

*** Records provided by email will be provided in Adobe PDF files that will be accessible to the email recipient via PCHC's secure messaging portal. An email will be sent to the email address you provide with instructions to the recipient on how to access such records via PCHC's portal.*

Health Information to be Disclosed

☐ My entire medical record (*complete "Sensitive Medical Information" section below if you wish sensitive types of health disclosed*)

☐ My medical records for the following dates ______________ to ______________

☐ Only the following specific types of medical records or information for the following dates: ______________ to ______________

☐ Clinical Records ☐ Immunization Records ☐ Lab Reports ☐ Hospital Records ☐ Radiology Reports ☐ Summary Records

☐ Other Records (specify): ______________________________

Unless I strike out this sentence, I intend this authorization to include disclosure of records and information the above disclosing person or organization has received from other healthcare providers, facilities or persons, unless such information may be withheld by law (see note below).

Sensitive Health Information

I specifically intend this authorization to include the disclosure of (*mark or initial all that apply*):

[____] **Mental and behavioral health records and information**, including (i) records and information maintained by licensed mental health facilities, programs and agencies, and (ii) records and information related to mental health services provided by licensed mental health professionals. *I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs or agencies at any reasonable time before deciding to authorize their disclosure on this form. (Note: licensed mental health facilities, programs and agencies may refuse to disclose information or records they have obtained from another individual or facility through an assurance of confidentiality, though you have the right to receive a summary description of such information.)*

[____] **Substance use disorder program records and information (subject to protection under 42 C.F.R. Part 2).**

[____] **HIV (Human Immunodeficiency Virus) / AIDS (Acquired Immune Deficiency Syndrome) information, including HIV test results, HIV/AIDS status, and medical records containing HIV/AIDS information.** *I understand that authorizing the disclosure of HIV/AIDS records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.*

Authorization of Continuing Communications and Subsequent Disclosures

Unless I strike out any of the following, I intend this authorization to authorize continuing communications and subsequent disclosures of information within the scope of this authorization (i.e., the disclosing and recipient parties of my health care information are authorized to have continuing communications concerning the health care information authorized to be disclosed by this form, and to disclose information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below).

I authorize the disclosure of the above information for the following purpose(s) (check applicable box(es)):

☐ At my request ☐ Treatment or Coordination of Medical Care ☐ Transfer of medical care ☐ Legal Matter or Proceeding

☐ Insurance coverage or payment purposes ☐ Other (specify): ______________________________

	Penobscot Community Health Care **Medical Records** Ph: (207) 404-8101 Fax: (207) 990-1248 Email: PCHCMR@pchc.com	**Patient Name:** **Date of Birth:**

Duration or Expiration Date/Event: This authorization will expire thirty (30) months from the date of my signature below, unless earlier revoked by me or unless I enter an earlier expiration date or event here:________________________ (date cannot exceed 30 months from date of signature). To the extent that this authorization authorizes disclosure of (i) mental health records and information maintained by a licensed mental health facility, program or agency, (ii) information concerning a child in a licensed residential care facility, or (iii) information concerning a child in a licensed foster care home, that part of the authorization will expire one (1) year from the date of my signature below, unless earlier revoked by me or unless I have entered an earlier expiration date or event in the space above.

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of some or all the above healthcare information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying PCHC in the manner described in PCHC's Notice of Privacy Practices (except to the extent that PCHC or any other person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- PCHC will not condition services or treatment on whether I sign this authorization, unless authorized to do so by law.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I have the right to a copy of this signed authorization.

________________ ____

Date Signature of Patient or Patient's Authorized Representative***

____

Printed Name

Authorized Representative's Legal Authority: ☐ Legal guardian ☐ Health care power of attorney agent
☐ Health care surrogate ☐ Parent of a minor

*** Signature by an authorized representative certifies to PCHC that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

FOR OFFICE USE ONLY
If the disclosure is by PCHC and the disclosure is partial or incomplete as compared to the patient's request, PCHC must notify the patient and recipient of the information that the disclosure is partial or incomplete by checking this box: ☐ *If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:* ***Notice to Recipient of Prohibition on Redisclosure:*** This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.
Received by:________________________ Location:______________________ Date: ________________ *Rev. 11/17/2022* *MRC001*