Enroll your child today!

All Bangor High School students have access to our
School-Based Health Center

Medical and Mental Health Services At School

Even if your child has a primary care provider elsewhere, he/she can receive immediate and on-site medical, and mental health care, ***right in school,*** at Bangor's School-Based Health Center (SBHC). This is possible through a program with Penobscot Community Health Care (PCHC).

Common Illnesses

- ☑ Asthma
- ☑ Strep Throat
- ☑ Cough, Fever, or Cold
- ☑ Acne or Rashes
- ☑ Vomiting & Diarrhea

Routine Exams

- ☑ Well-Child/Annual Exams
- ☑ Immunizations

Sports Related Concerns

- ☑ Sprains and Strains
- ☑ Stitches
- ☑ Sports Injuries
- ☑ Sports Physical Exams
- ☑ Concussion Management

Mental Health Services

- ☑ Treatment For:
  - *Anxiety*
  - *Depression*
  - *Stress Management*
  - *Changes at School or Home*

At our School-Based Health Center, We Care For ALL of You...

From routine medical exams and common illness treatments, and mental health, our PCHC health professionals are there for your care!

When your child is enrolled at the SBHC, he/she is able to get the care they need *right down the hall.* This saves you time driving to or from appointments, and your child is able to return quickly to class. *This service is even available to students who don't feel well enough to attend school and are absent!*

NOTE: Your child does <u>not</u> need to be a PCHC patient to enroll in this program.

Sign up today! Call 207-404-8247 with any questions.

More info about Bangor School-Based Health Centers and PCHC available online at **www.PCHC.com**

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Bangor School-Based Health Center
Bangor High School

Instructions:
1) Fill in requested info
2) Print forms
3) Sign and date page 2 of each form
3) Return signed forms to the school-based health center

Print Forms

SBHC Enrollment and Consent Form

Student Information

Student Name _____ Date of Birth _____ Current Grade _____

Student Cell Phone _____ Text appt reminders to this #? ◯YES ◯NO SSN _____ H.S. Graduation Year _____

Street Address _____ City, State Zip _____

Name of PCP _____ Phone _____ Date of Last Physical _____

☐ My child does not have a primary care provider ☐ I'd like to use the SBHC provider as my child's PCP

Parent/Legal Guardian Information

1. Parent/Guardian Name _____ Relationship _____

   Primary Phone _____ Alternate Phone _____ Email _____

2. Parent/Guardian Name _____ Relationship _____

   Primary Phone _____ Alternate Phone _____ Email _____

Insurance and Guarantor Information

☐ **Primary Health Insurance** - Insurance Company _____ Policy/ID # _____

Name of Subscriber *(insured parent/guardian)* _____

Subscriber Date of Birth _____ Subscriber SSN _____ Subscriber Phone _____

Address _____ City, State Zip _____

☐ **Secondary Health Insurance** - Insurance Company _____ Policy/ID # _____

Attach a copy of your insurance card (back and front) or call our billing office to provide your plan information at 404-8100

☐ **Medicaid/MaineCare** ID# _____ Name *(as printed on ID 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/

Guarantor Name *(person financially responsible)* _____ Relationship _____

Primary Phone _____ Date of Birth _____ SSN _____

Billing Address _____ City, State Zip _____

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 ◯Sign Language ◯French ◯Spanish ◯Other Hispanic/Latino ◯Yes ◯No

Race ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

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

Sexual Orientation ◯Straight/Heterosexual ◯Lesbian or Gay ◯Bisexual ◯Something else ◯Don't know ◯Choose not to disclose

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

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

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

Number of people living in your household? _____

Household income ◯$0-$10,000 ◯$10,001-$15,000 ◯$15,001-$20,000 ◯$20,001-$25,000 ◯$25,001-$30,000 ◯$30,001-$35,000
◯$35,001-$40,000 ◯$40,001-$45,000 ◯$45,001-$50,000 ◯$50,001-$55,000 ◯$55,001-$60,000 ◯$60,001-$65,000
◯$65,001-$70,000 ◯$70,001-$75,000 ◯$75,001-$80,000 ◯$80,001-$85,000 ◯$85,001-$90,000 ◯>$90,001

Bangor School-Based Health Center
Bangor High School

SBHC Enrollment and Consent Form

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 questionnaire. My insurance may be charged for this visit, but I will not be responsible for any out-of-pocket expense.

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 at Bangor High school.

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 fess 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 Bangor High 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 of the above statements. All of 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.*

Penobscot Community Health Care Medical Records P.O. Box 439 Bangor, ME 04402-0439 Phone: (207) 404-8101 Fax: (207) 990-1248 Email: MedicalRecordRequests@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: Bangor School Department

City/State/Zip Code: Bangor, Maine 04401

Phone: (207) 942-4152 Fax: _____

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

☑ Verbal Communication ☑ other (*specify instructions*): Print

** 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): SBHC enrollment status, appointment date and time

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 (*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): Facilitating appointment attendance

PCHC	Penobscot Community Health Care Medical Records Ph: (207) 404-8101 Fax: (207) 990-1248 Email: MedicalRecordRequests@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: _____

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