Pueblo Community Health Center

School-Based Wellness Center
Patient Information Form
PLEASE PRINT (One student per form)

Student (Patient) Name_____Date of Birth_____Social Security # _____

Address_____City_____State_____ZIP_____

Home phone #_____Sex (circle) M F Grade_____School_____

Parent/Guardian Name _____ Date of Birth_____Relationship to Student_____

Phone # Home/Work_____ Email address_____

Emergency contact person _____ Phone # _____

Family Physician/Clinic _____ Phone # _____

Guarantor Information (Person Responsible for Payment of Accounts/Services)

Complete if different from Parent/Guardian

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Social Security # _____-_____-_____ Relationship to Patient: _____

Mailing Address: _____City:_____ State: _____ Zip:_____

Phone(s): Home: (____) _____-_____ Cell: (____) _____-_____

Employer: _____ Work Number: (____) _____-_____

Insurance Information
(Provide current copy of insurance card to PCHC staff)

Name of Insured: _____Name of Insurance_____

Policy Number: _____ Group Number: _____ Policyholder Name: _____

Effective Date: _____ Patient's Relation to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policyholder SSN#: ___/_____/_____ Policyholder DOB: _____

Secondary Insurance Name: _____ ID# _____

Additional Information
Please answer the following questions in order for us to better serve you

What language is preferred? ☐ English ☐ Spanish ☐ Other _____

Over the past 24 months, have you (patient) or a member of your family:

Been hired to do agricultural work like: planting, picking, packing house, driving truck for any type of farm work, worked with animals like cows, chickens, etc.? ☐ Yes ☐ No

Lived away from home in order to work in any type of agriculture (farm work)? ☐ Yes ☐ No

Stopped working in agriculture because of disability or age (too old to do work)? ☐ Yes ☐ No

Are you presently living with friends or family, in your car, in a shelter, in a hotel or on the street? ☐ Yes ☐ No

Ethnicity: Check one of the following ethnic groups that best pertains to you (patient).
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: Check one of the following racial groups that best pertains to you (patient).
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White (including Whites of Latino/Hispanic descent)
☐ Black/African American (including Blacks or African American of Latino/Hispanic descent)
☐ American Indian/Alaska Native (including American Indians or Alaskan Natives of Latino/Hispanic descent)

Household Size: _____ Monthly Household Income: _____ ☐ Decline to disclose

See back

CONSENT TO TREATMENT AND DISCLOSURE

Student (Patient) Name: _____

Date of Birth: _____ **Phone Number:** _____

Pueblo City/County Schools and Pueblo Community Health Center have established a School-Based Wellness Center (SBWC) program to provide primary health care and behavioral health services to its students. Services provided through the SBWC program include, but are not limited to, diagnostic treatment and services, individual and family therapy, patient education, and administration of immunizations (immunizations may require a *separate* consent). I voluntarily request and consent to the rendering of health care and behavior care services by the SBWC, its staff, and providers. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

Parental/ Guardian involvement and notification. Colorado law may prohibit the SBWC and its providers from informing parents/guardians of mental health problems, substance abuse issues, eating disorders, pregnancy matters, family planning, including birth control, and diagnosis or treatment of sexually-transmitted diseases without the patient's permission. For the purpose of these conditions, the patient may enter into a confidential and privileged relationship with the SBWC provider. However, it is the SBWC's practice to attempt to gain permission from the patient to inform his/her parent(s), guardian, or a caring adult when one or more of these conditions are present. When permission is not granted, the SBWC staff will strongly encourage the student to communicate their condition to their parent(s) and/or guardian. Parents, guardians, or other authorized representatives with questions about SBWC services are encouraged to contact the SBWC with their inquiries.

Confidentiality and release of information. I hereby authorize the SBWC to release information from the patient's medical records for treatment, payment, healthcare operations, and other purposes as permitted by applicable state and federal law, including the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including to any health care provider, the school's nursing staff, and other SBWC staff who is involved in any way with the care of the patient and to any person or entity which is or may be liable for all or part of the charges for services, goods, or facilities provided to the patient. I understand that following release of this information, the SBWC cannot control its confidentiality. I also give consent to and authorize the SBWC staff to examine the patient's school records, attendance, and other records as necessary to assist the SBWC staff with the patient's diagnosis and treatment. I understand refusal to authorize disclosure of the patient's health information to a health benefit plan (including health insurance, discount benefits program, government health programs, etc.) will have no effect on my enrollment, eligibility for benefits under the SBWC program.

Financial responsibility and assignment for direct payment. I hereby authorize the SBWC and its providers to bill any health benefit plan (including health insurance, discount benefits program, government health programs, etc.) that may be responsible for providing coverage and/or payment for service provided to the patient by the SBWC. In the event the patient does not have health care coverage, the SBWC and its providers will provide treatment and services and the parent/guardian will be responsible for any charges. The parent, or guardian may complete a financial eligibility screening to determine if the patient qualifies for any health care assistance programs that help with the cost of the patient's care. I hereby authorize payment to be made directly to the SBWC and its providers, not to exceed the amount of their regular charges, otherwise payable to me for my health care services, good, and facilities provided. I understand that there is no guarantee of reimbursement from any health benefits plan or other payer and that I may be financially responsible for all charges not paid for any reason by my health benefit plan or other payer within a time period the SBWC deems reasonable. Co-payments and/or deductibles associated with any health benefit plan will be assessed and collected. In addition, it may be necessary to refer the patient to the hospital, specialists, or other health care providers for recommended treatment in order to provide quality health care. These providers may have separate charges for these services which will be the responsibility of the student/parent/guardian and are not covered by this consent form.

Acknowledgement and termination of this consent form. I understand this consent will remain in force until the patient is no longer enrolled at the patient's current school. I also understand that I may revoke this authorization at any time, in writing, except to the extent that the SBWC has already acted on my permission. It is the parent/guardian's responsibility to notify the SBWC about changes in guardianship.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM, UNDERSTAND ITS CONTENTS, AND HAVE RECEIVED A COPY HEREOF. I ACKNOWLEDGE THAT I HAVE REVIEWED PUEBLO COMMUNITY HEALTH CENTER'S PRIVACY NOTICE. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT OR A PERSON AUTHORIZED BY THE PATIENT OR OTHERWISE TO SIGN AND ACCEPT THIS AGREEMENT AND CONSENT ON BEHALF OF THE PATIENT.

_____ _____

DATE **SIGNATURE OF PATIENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE**

_____

PRINT NAME

Authorized Use Only
Staff Initials: _____ Dept: _____
New Patient: ☐ Yes ☐ No
FPT ☐ FHT ☐ IZ's ☐ SBWC Non-Medical ☐

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