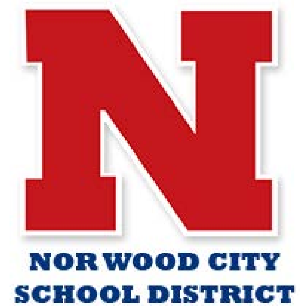
333 Conover Dr, Ste B, Franklin, OH 45005
231 N Breiel Blvd, Middletown, OH 45042
Phone: 513.318.1188



Centerpoint Health is happy to partner with Norwood City Schools to help students and the Norwood community have access to high-quality healthcare from the convenience of your school building.

What we offer:

- Telehealth services for students who are ill
- On-site medical and dental services
- Behavioral Health appointments by telehealth

What you need to do:

Complete these forms and return them to Centerpoint Health:

- Email completed forms to registration@centerpointhealth.org, or
- Send them with your child to school

CENTERPOINT HEALTH
SCHOOL-BASED HEALTH SERVICES
ENROLLMENT PACKET

Welcome to Centerpoint Health (CPH) School-Based Health Services (SBHS).

This center is very unique being school based. It offers the students and community member's access to medical care when it might otherwise not be available. We operate year round, and parents and/or guardians are always welcome at the appointments, but they are not required to be there. After the first year, personal information which changes needs to be updated. Examples -grade in school, school building, school district, addresses, phone numbers, medical history, insurance information, etc.

Once the student's completed consent and history are received, we will begin scheduling appointments for approved services. You will receive a notice of the student's appointment time by phone or note from school. If we do not receive a request to change the appointment, we will proceed as scheduled.

- Complete the required documents and return to school with the student or drop off at the health center.
- Scheduling may be delayed if there are missing documents or information is illegible.

Please feel free to contact us during regular business hours at **(513) 318-1188** if you have any questions.

STUDENT INFORMATION & CONSENT FOR SERVICES				
Today's Date:	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:
Student's Current School:	Student's Current Building:	Student's Current Grade:	Student's Current School ID #:	

PRIMARY CARE SERVICES

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including well child exams (includes work, daycare, and sports physicals), appropriate immunizations, appropriate behavioral evaluations, integrated behavioral health services, and treatment for illness or injury including over the counter medications unless emergency services are needed.

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the School-Based Health Center.

DENTAL SERVICES

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at the school-based / mobile dental office including preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants and other preventive procedures will also be provided. The treatment plan will be provided and approved by the parents/ guardian PRIOR to starting treatment.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES** at the School-Based Health Center.

By signing this consent, I agree to the terms and conditions regarding Payment for Services & Sharing of Health Information as explained in the accompanying Program Description form. I have also received and agree with the Patient Consent for use and Disclosure of Protected Health Information as explained in the Program Description form. I have received the Notice of Privacy Practices. I agree to allow Norwood City Schools to share insurance information with Centerpoint Health. I understand and agree that this consent will remain in effect until I revoke it or until my child is no longer enrolled in a school district where Centerpoint Health provides services.

Parent or Guardian Signature or Patient/Student Signature (Only if 18 or older)	Parent/Guardian Printed Name or Patient/ Student Printed Name (Only if 18 or older)	Date

CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

PATIENT INFORMATION

Last Name:	First Name:	MI:	Age:	Birth Date:	Social Security #	Gender (at birth): ☐ Male ☐ Female
Home Address: ☐ *Check if Homeless*	City:	State:	Zip Code:			
Home Phone:	Cell Phone:	Email Address:				
May we leave you a voicemail message on the phone number(s) provided: ☐ Yes ☐ No						
Emergency Contact:	Relationship:	Primary Phone:				

RESPONSIBLE PARTY (*Required if patient is under the age of 18 or is an adult with a proxy/legal guardian.*)

Last Name:	First Name:	MI:	Birth Date:	Social Security # ______-_____-______	Relationship:
Home/Billing Address:	City:	State:	Zip Code:		
Home Phone:	Cell Phone:	Email Address:			

ADDITIONAL INFORMATION

Race (check all that apply): ☐ White/Caucasian ☐ African American/Black ☐ American Indian/Alaska Native ☐ More than One Race ☐ Native Hawaiian/Other Pacific Islander ☐ Asian	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino		
Language: ☐ English ☐ Spanish ☐ Other: _______________	Gender Identity: ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Decline to Answer ☐ Other: _________________________		
I request translation services: ☐ Yes ☐ No			
Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't Know ☐ Other: ____________	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	How did you hear about us? ☐ Flyer ☐ Website ☐ WIC ☐ Billboard ☐ Referral ☐ Walk-in ☐ Radio ☐ Social Media ☐ Insurance Provider ☐ Friends/Family ☐ Other: ________________	Do you have an Advance Directive or a Living Will? ☐ Yes ☐ No Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No

CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

<table>
<tr>
<td>
<u>Income and Dependents</u>
No. of Dependents (including youself) __________

Annual Range – Check one box only
☐ None - $10,000.00
☐ $10,001.00 - $15,000.00
☐ $15,001.00 - $20,000.00
☐ $20,001.00 - $25,000.00
☐ $25,001.00 - $30,000.00
☐ $30,001.00 - $40,000.00
☐ $40,001.00 - $50,000.00
☐ $50,001.00 - $60,000.00
☐ Over $60,000
</td>
<td>
Is the patient...:

... a migratory or seasonal migratory worker? ☐ Yes ☐ No
... a veteran? ☐ Yes ☐ No
... disabled? ☐ Yes ☐ No
</td>
</tr>
</table>

Do you have Medical Insurance? ☐ Yes ☐ No
Medical Insurance Provider: _________________ Subscriber No: ___________________ Group No: _________
Name of Insured: __________________________ Insured's Employer: _______________________ Co Pay_______

Do you have Dental Insurance? ☐ Yes ☐ No
Dental Insurance Provider: __________________ Subscriber No: ___________________ Group No: _________
Name of Insured: __________________________ Insured's Employer: _______________________ Co Pay_______

PERMISSION TO SHARE MY HEALTHCARE INFORMATION

In the course of your care, Centerpoint Health recognizes you may wish to involve certain family members, friends, and others to be involved by giving and receiving information about the care you received. In order to assist you, we ask that you identify those individuals, if any, in the space below. This does not authorize any copies of medical records, which will require a written patient authorization. This permission is in effect until it is revoked in writing to Centerpoint Health. You will need to provide an identifier to any individual to ensure the person calling has been given permission.

Name of Individual	Relationship to Patient

____

Patient's Printed Legal Name

____ ______________________________

Signature of Patient or Responsible Party *Date*

Pediatric Patient Health History

Name of Patient ______________________ Patient's Date of Birth ______________________

Name of Person Completing Form ______________________ Relationship ______________________

Are you the patient's legal guardian? Yes________ No________

Part 1: Please list all medications on the other side of this form.

Part 2: Do you have, or have you had, any of the following? Please check all that apply:

- ☐ Cancer or tumor
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hay fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma

Part 3: Are you allergic to or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics such as Novocain
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other: ___________________________

Part 4: Are you taking any of the following:

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine

Women:

- ☐ May be pregnant
  Expected Delivery Date: _______________________
- ☐ Taking hormones or contraceptives

Do you smoke or use chewing tobacco? Yes No

Does your child have any disease, condition, or problem not listed above? ☐ Yes ☐ No *(If yes, please explain on reverse.)*

Has your child had any previous hospitalizations? ____

What medical problems run in the family and who has them? ____

____

Who lives at home with the child? ____

Describe any medical or dental concerns you would like to discuss with the providers today: ______________________

____

Notification of Sliding Fee Discount Application

Must be completed prior to service.

NOTE: Your signature to request or waive the Sliding Fee Discount Application must be signed in order for you to be seen by a Centerpoint Provider.

All patients seeking services are assured they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay so long as they complete and are found eligible in the application process.

Please sign to either request or waive the Sliding Fee Discount Application:

Request
the Sliding Fee Discount Application

Requests for discounted services may be made by patients, family members or others who are aware of existing financial hardship. Discounts are offered based upon family income and size. Our services include Family Medicine, Pediatrics, Obstetrics/Gynecology, Dental, and Behavioral Health. Information and forms can be obtained by acknowledging your consent to receive this information.

____
Printed Patient Name

____
Patient Signature

____
Date

OR

Waive
the Sliding Fee Discount Application

I choose **not** to receive the Sliding Fee Application at this time. I waive my right to any discount for which I may otherwise be entitled. I understand I will be responsible for full payment of all charges at the time of service.

Do not sign in this space if you would like to apply for the Sliding Fee Discount.

____
Printed Patient Name

____
Patient Signature

____
Date

Fundraising / Publicity / Media Release

I, _____________________________________ , have decided of my own accord to be interviewed, photographed and/or quoted for Centerpoint Health fundraising, publicity and/or media use. Centerpoint Health is not responsible for my decision to do so, and I hold Centerpoint Health harmless in this matter.

____ _______________________________

Signature *Date*

____ _______________________________

Signature of Guardian, if patient is younger than age 18 *Date*

____ _______________________________

Signature of Witness *Date*

If applicable:

____

Event / Location

____

Name of Minor