CENTERPOINT NORWOOD
SCHOOL-BASED HEALTH CENTER
ENROLLMENT PACKET

Welcome to the Centerpoint Norwood School-Based Health Center (SBHC).

This center is very unique being school based. It offers students, staff, and community members 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 include grade-year 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: Month / Day / Year	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth: Month / Day / Year

Student's Current School:	Student's Current Building:	Student's Current Grade Year:	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 Centerpoint Norwood 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 parent or guardian PRIOR to starting treatment.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES** at the Centerpoint Norwood 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	Marital Status:	How did you hear about us?	Do you have an Advance Directive or a Living Will? ☐ Yes ☐ No Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No
☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't Know ☐ Other: _____	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	☐ Flyer ☐ Website ☐ WIC ☐ Billboard ☐ Referral ☐ Walk-in ☐ Radio ☐ Social Media ☐ Insurance Provider ☐ Friends/Family ☐ Other: _____	

CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

Income and Dependents	Is the patient...:
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	... a Migratory or Seasonal Migratory Worker? ☐ Yes ☐ No ... a Veteran? ☐ Yes ☐ No ... disabled? ☐ Yes ☐ No

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*

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

Missed Appointment Contract

Patient Name: _____

I understand the following Centerpoint Policies:

Missed Appointment Policy: I understand if I miss three (3) appointments in a twelve (12) month period, my patient-physician relationship may be terminated.

Cancellation Policy: I understand if I do not call before the appointment, it will count as a no-show.

For these appointments:	**I need to cancel:**
Medical	2 hours before the appointment
Dental	24 hours before the appointment
Behavioral Health	24 hours before the appointment
Psychiatry	24 hours before the appointment

Appointment Confirmation Policy: I understand if I do not confirm my appointment prior to the day of the appointment, it will be cancelled.

I agree to follow the rules below to continue with the patient-physician relationship:

1. I will come to all scheduled appointments on time.
2. I will arrive for my appointment fifteen (15) minutes prior to the scheduled time to complete or update my registration information.
3. I will call two (2) hours prior to the scheduled time to cancel a medical appointment or twenty-four (24) hours prior to a dental, psychiatry, or behavioral health appointment.
4. Failure to comply with these rules will result in a note being placed in my chart for a no-show.
5. I understand that if I miss three (3) appointments in any twelve (12) month period that my patient-physician relationship may be terminated.

I have read and understand the rules listed above. I have had a chance to ask Centerpoint Health's staff any questions that I may have. I agree to follow these rules and understand the consequences of not doing so.

_____ _____

Signature of Patient or Responsible Party *Relationship*

_____ _____

Staff 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

Release of Prescription Information
ePrescribe Program

ePrescribe is a way for your healthcare provider to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program includes:

- **Formulary and benefit transactions** give the health center provider information about which drugs are covered by your drug benefit plan.
- **Fill status notifications** allow the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** provide the health care provider with information about potential medication and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interactions, adverse drug reactions, and duplicative therapy.

The medication history information can include medications prescribed by your health care provider at Centerpoint Health as well as other health care providers involved in your care. This information may reveal sensitive information including, but not limited to, medications related to a mental health condition, sexually transmitted diseases including HIV and AIDS, substance (drug and alcohol) abuse, and genetic diseases.

By signing this consent form, you are specifically informed and consent to have prescriptions transmitted electronically and know sensitive information about you may be revealed by the nature of the prescription. The receiving pharmacy is also required to protect this personal health information about you.

By signing this consent form, you agree your provider at Centerpoint Health may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decline to sign this form. Your choice will not affect your ability to get health care, payment for health care, or your health care benefits. You also have a right to receive a copy of this form after you have signed it. This consent will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing; however, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide consent to Centerpoint Health to enroll myself in to the ePrescribe Program. I have complete understanding of the ePrescribe Program. All my questions about the program were answered to my satisfaction prior to giving my consent.

_____	_____
Printed Legal Name of Patient	*Patient's Date of Birth*
_____	_____
Signature of Patient or Responsible Party	*Date*

RX Consent- *Patient's or Authorized Person's Consent: A code used to indicate whether the provider has a signed statement on file granting permission to view a patient's prescription history from external sources.*

Patient's Rights and Responsibilities

As a patient, you have the right:

- To receive quality health care regardless of your age, sex, religion, nationality, sexual preference, disability, health status, or income status;
- To safe, considerate, and respectful care from all Centerpoint Health staff;
- To receive complete information about your diagnosis, treatment, and prognosis in a manner you can understand;
- To confidentiality of all information regarding to your care and medical conditions to the extent expected and permitted by law, including all records and communications;
- To have special needs met, such as an interpreter to help with communication;
- To be seen in a clean and safe environment;
- To make decisions and give instructions about your medical care in advance and to have them followed;
- To appoint a person to make health care decisions on your behalf in the event you are unable to make those decisions;
- To file a complaint about your care without fear of penalty and to have your complaint reviewed and, if possible, resolved.

As a patient, you have the responsibility:

- To provide, to the best of your knowledge, complete information about your symptoms, past illness, medications, and other matters relating to your plan of care;
- To schedule and keep appointments or call to cancel your appointment if you cannot be there, two hours prior for medical appointments and 24 hours prior for all other appointments;
- To notify Centerpoint Health of any changes in address, insurance, or family members;
- To provide a current copy of your insurance card and notify Centerpoint Health when there are changes in insurance coverage;
- To ask questions when you do not understand explanations about your care or services;
- To be responsible for your actions if you refuse treatment or do not follow your service provider's instructions;
- To be courteous and considerate to all Centerpoint Health staff and other patients.

_____ _____

Signature of Patient or Responsible Party *Date*