GENERATIONS
FAMILY HEALTH CENTER

Welcomes you and your child....

to the **SCHOOL BASED HEALTH CENTER,** located at Putnam Middle School!

Your child's school values the importance of good health, and has partnered with us to bring these unique services into the school.

Children enrolled in this program can receive medical, dental or behavioral healthcare from our friendly, professional staff right in the school. This means more time in school for your child and more convenience for you!

Our clinicians will only provide the care that you and your child feel is necessary. If your child already has a medical, dental or behavioral health care provider, we will work directly with that clinician to ensure good communication and the right care for your child. Otherwise, we are happy to become your child's primary care provider!

Children may access just one of the services, or all of them. Also, these services are available throughout the school year. So you can enroll your child in the SBHC program at any time. Now is a great time to sign up, so your child is set for whatever the school year brings!

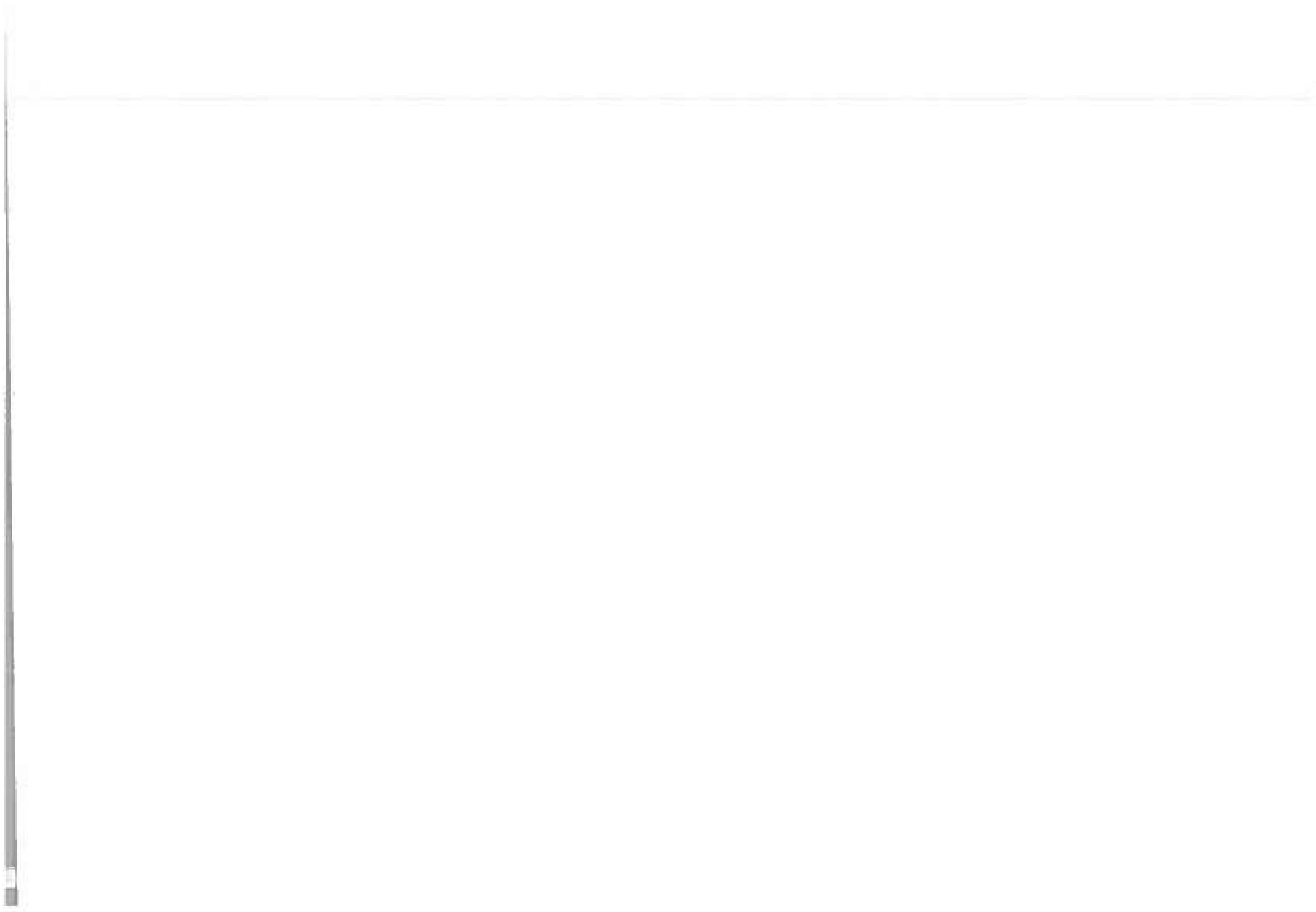
As needed, we will be communicating with you about the care your child has received, and if there are any recommendations for further care. However, you are welcome to contact us with questions at any time. Services are also available at our other Putnam location, at 202 Pomfret St., if that is more convenient. Call 860-963-7917 for that site.

We look forward to meeting you and your child! Call 860-928-4698 for more info or an appointment at the School Based Health Center!

PLEASE ONLY COMPLETE THE ENCLOSED FORMS IF:

1) Your child has never been seen at the school based health center

OR 2) It has been a year or more since your child has been seen there



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Patient Information & Consent for Treatment

Grade:

If you would like to enroll your child in this program, or it has been a year or more since he/she was seen here, please answer ALL questions on this form. We require this information is updated every school year. Thank you.

Child's Name: (first) ____________________ (last) ____________________ MI ______

SS#: _______-_______-_______

Child's Home Address: (street) ____

(town) ______________________________ (zip code) ______________

Date of Birth: _____/_____/_______ ☐ Male ☐ Female Primary Language: ______________

Child's Race: (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐Other: ______________

Ethnicity: Is the child of Hispanic Origin? ☐ Yes ☐ No

Parent/Guardian Name: (first) ____________________ (last) ____________________

Relationship to Child: ______________________________ DOB:_______/_______/_______

Address: (street) ____________________ (town) ____________________ (zip code) __________

Daytime Phone: ____________________ Cell Phone: ____________________

May we communicate with you by email after each visit to keep you informed? If yes, please provide email address.

Email Address: ____

Employer: ______________________________ Phone: ______________

Emergency Contact: ______________________________ Phone: ______________

Family Doctor: ______________________________ Phone: ______________

Pharmacy: Phone:

Please complete information below on any insurance coverage you child may have at this time.

	Medical Insurance	Dental Insurance	Behavioral Health Ins.	Secondary Insurance
Plan Name:				
Policy #				
Group #				
Subscriber Name:				
DOB:				
Relationship:				

If your child has no insurance, would you like to talk with our staff about health care coverage? ☐ **Yes** ☐ **No**

PT#

Please continue to next page

SBHC 7.20.2016

INCOME DOCUMENTATION

It is the policy of Generations Family Health Center, Inc. to provide essential services regardless of the patient's ability to pay. Discounts may be offered based upon family/household size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

Family size: ______________________________(including unborn child if pregnant)

Household gross income: $___________________________ per (circle one): WEEK BIWEEKLY MONTH YEAR

All of the above information is required

Families who meet certain income guidelines are eligible to apply for sliding fee scale discount. Please contact our office if you would like more information on how to apply for this discount. We reserve the right to verify eligibility for reduced charges. Pay stubs or other financial information may be required.

Effective February 1, 2016		**2016 Federal Poverty Guidelines – Income Ranges**						
Family Size	**<100%**	**101-125%**		**126-150%**		**151-200%**		**200%+**
		FROM	**TO**	**FROM**	**TO**	**FROM**	**TO**	**AT LEAST**
1	$11,880	$11,881	$14,850	$14,851	$17,820	$17,821	$23,760	$23,761
2	$16,020	$16,021	$20,025	$20,026	$24,030	$24,031	$32,040	$32,041
3	$20,160	$20,161	$25,200	$25,201	$30,240	$30,241	$40,320	$40,321
4	$24,300	$24,301	$30,375	$30,376	$36,450	$36,451	$48,600	$48,601
5	$28,440	$28,441	$35,550	$35,551	$42,660	$42,661	$56,880	$46,881
6	$32,580	$32,581	$40,725	$40,726	$48,870	$48,871	$65,160	$65,161
7	$36,720	$36,721	$45,900	$45,901	$55,080	$55,081	$73,440	$73,441
8	$40,860	$40,861	$51,075	$51,076	$61,290	$61,291	$81,720	$81,721

**The federal poverty guidelines are updated annually.*

PERMISSION TO TREAT

Please read the information below, and indicate which services you would like available to your child, and your consent for that treatment to occur. We will always have contact with you prior to your child being seen for any service, but this written permission will assist the process when your child needs care. Medical care is provided by a Nurse Practitioner (APRN), Dental care by a Hygienist (RDH), and Behavioral Health Care by a Therapist (LPC/LCSW). This permission extends throughout the 2016-2017 school year.

1. I give my permission to provide the following care for my child: ***(please circle each you are consenting to)***

   MEDICAL CARE **DENTAL CARE** **BEHAVIORAL HEALTH CARE**

2. I understand I will be informed of all treatment received, as allowed under CT State Law.
3. I understand and allow for the following, regarding the release of information on my child's health care: I understand that you will bill my insurance. If I do not have insurance I understand that I am responsible for payment and am able to make arrangements for a payment plan. I allow the release of information as needed for billing purposes and will request that the insurance company address claims by directing payment to Generations Family Health Center, Inc. It is my right to so assign these benefits.
4. I also give permission to share health information with the school nurse and insurance companies as it relates to treatment that may be provided.
5. My signature below affirms my consent to the above Permission for Treatment and I also affirm that the information given on all parts of this form, including the Health History and the insurance information is accurate and complete to the best of my knowledge.

   Parent or Guardian Signature: ________________________________ Date: ____________

   Printed Name: __________________________________ Relationship: ____________

NOTE: If you are a Legal Guardian, please attach copies of the court record documenting this.

(This documentation is required prior to any treatment being done.)

PT#

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Child & Family Health History

PT#: ____________

Child's Name: ________________________________ ***CHILD'S HEALTH HISTORY (needed for ALL services)***

1. Does your CHILD currently have a primary medical care provider? If YES, please tell us who: ________________
2. Is your CHILD currently being treated for any health issues? If Yes, please explain: ________________________
3. Is your CHILD currently being prescribed any medications? If Yes, please list medication names and dosages: ________________________
4. Does your Child have a history of any of the following, and if YES, please explain.

Y	N	Condition	Y	N	Condition
Y	N	Asthma	Y	N	Stomach or bowel problems
Y	N	Allergy to any foods or medications	Y	N	Seizures or fainting spells
Y	N	Allergy to pain medications (pills/Novocain)	Y	N	Frequent Cough
Y	N	Hospitalizations or Surgeries	Y	N	Endocrine or hormone problems
Y	N	Tuberculosis	Y	N	Frequent headaches
Y	N	Diabetes	Y	N	Liver (Hepatitis)
Y	N	Disabilities	Y	N	Recurrent infections
Y	N	Heart murmur or defect	Y	N	Hives or skin rash
Y	N	Rheumatic fever	Y	N	AIDS or HIV infection
Y	N	Bleeds or bruises easily	Y	N	Anemia or Sickle Cell Anemia
Y	N	Allergy to Latex (gloves or band aids)	Y	N	Vision problems
Y	N	Is the child pregnant? (females only)	Y	N	Kidney problems
Y	N	Problems with learning or understanding instructions	Y	N	Religious or cultural beliefs which the provider should consider in planning treatment
Explain:					

5. When and where was your child's last physical exam? ________________________________
6. Does your child have any other health condition not listed above, or do you have another health concern for your child? YES NO If yes, please explain: ________________________________

FAMILY HEALTH HISTORY (please indicate family member with the following conditions)

Cancer (describe type) ________________________
Hypertension (high blood pressure) ________________________
Heart Disease ________________________
Diabetes ________________________
Stroke ________________________
Mental Illness (anxiety, depression, etc.) ________________________

Child and Family Health History Reviewed By:

Medical Provider Signature: ________________________ ***Date :*** ____________

If child is being seen by a Dental or Behavioral Health provider, please complete other side:

PT#: ___________

ONLY FOR STUDENTS REGISTERING FOR DENTAL SERVICES:

1. Has your child ever seen a dentist before? YES NO If yes, where and when was he/she last seen? ______________________
2. Has your child ever had dental x-rays? YES NO If yes, where and when were the last x-rays? ______________________
3. Does your child currently have a dental problem? YES NO If yes, please explain: ______________________
4. Have you ever been told your child should take medication before a dental procedure? YES NO If yes, please explain: ______________________
5. Has your child ever had any problems with a previous dental experience? YES NO If yes, please explain: ______________________
6. Has your child ever had any severe dental trauma? YES NO If yes, please explain: ______________________

History review includes child and family health history on front of form.

______________________ ______________

Dental Provider Signature ***Date***

ONLY FOR STUDENTS REGISTERING FOR BEHAVIORAL HEALTH SERVICES:

(For any questions that you answer YES, please explain details down below in the space provided.)

1. Does your child currently see a behavioral health clinician? YES NO If yes, tell us who: ______________________
2. Is your child currently prescribed any medications for a behavioral health condition? YES NO If yes, please list the names and dosages: ______________________
3. If your child does not currently participate in therapy, has he/she ever received services in the past? YES NO
4. Has your child ever been treated by a therapist or diagnosed with symptoms of depression? YES NO
5. Has your child ever been diagnosed with or treated for symptoms of anxiety? YES NO
6. Is there a family history of mental health issues? YES NO
7. Has your child ever been diagnosed with a psychiatric issue? YES NO
8. Has your child ever been treated in a residential facility for psychiatric issues? YES NO
9. Does your child have a history of an eating disorder? YES NO
10. Has your child ever been hospitalized or treated for a suicide attempt? YES NO
11. Has your child ever reported thoughts about harming themselves? YES NO
12. Has your child hurt someone else or destroyed property within the past 6 months? YES NO
13. Does your child have any modifications in school such as an IEP or 504 plan? YES NO
14. Has your child ever been suspended or expelled? YES NO
15. Has your family ever been involved with the Dept. of Children & Families? YES NO
16. Has your child ever been arrested or on probation for an arrest? YES NO
17. Has your child ever witnessed or been the victim of abuse or neglect? YES NO
18. Does your child have any unusual eating habits? YES NO
19. Does your child participate in after school activities, sports or clubs? YES NO
20. Is the child able to form and maintain relationships with peers? YES NO
21. Is there currently any conflict in the family? YES NO

Comments: ______________________

History review includes child and family health history on front of form.

______________________ ______________

Behavioral Health Provider Signature ***Date***

About our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- our rights to change our Notice of Privacy Practices
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

We are required by law to give you a copy of this Notice and to obtain your written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt

I, ________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

________________________________ ____________

Patient's Signature Date

________________________________ ____________

Signature of Patient's Representative (if applicable) Date

____

Description of Legal Authority to Act on Behalf of Patient