**DOCTORS PLUS KIDS CARE CLINIC**

**850 West Beaver Creek Blvd/PO Box 8432**

**Avon, CO 81620(970) 328-2905/(970) 688-7101 (f)**

**School Based Health Center (SBHC) STUDENT ENROLLMENT AND REGISTRATION FORM**

***This form enrolls the student in the SBHC’s physical, mental and oral health programs.***

**School Name** (where Student is enrolled): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Legal Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Sex:  M F Grade: \_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

**Race**  American Indian or Alaskan Native  Asian  Caucasian  Negro or African American

 Hawiian or Pacific Island Native  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Refused to answer

**Ethnicity:**   Hispanic Non Hispanic  Other: \_\_\_\_\_\_\_\_\_\_  Refused to answer

**Parent Information (Circle One: Parent or Guardian)**

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Daytime/Work: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:  Same as Student

  Other Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact (*other than Parent*)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime/Work: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

**Designated Alternative Caregiver**  I (Parent/Guardian Name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, designate the following individual as an **alternate caregiver** of my child who may transport and/or authorize medical care on my child's behalf. ***Photo ID may be required at time of service.***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime/Work: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I **decline** to designate an alternative caregiver.

**Parent/ Guardian Consent for Treatment**

Does the patient currently receive the following care? Medical  Behavioral-Mental  Dental  None

 My child does not receive regular health care from any other provider.

 My child receives regular health care from the following provider(s) (doctor/clinic):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the parent/guardian, for this patient, I hereby consent for my child to 1) receive care as needed at the SBHC, 2) receive care coordination services and 3) for any and all records or prescriptive medication information to be obtained and/or released to and from the above provider(s) as needed for necessary care by the SBHC.

**Treatment of MINORS in Colorado**

I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to the Colorado State law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature *(parent, guardian or emancipated minor)* Date**

**School Based Health Center (SBHC) STUDENT ENROLLMENT AND REGISTRATION FORM (PAGE 2)**

**Insurance Information:** Do you have health insurance, Medicaid or CHP+? Yes/ No (circle)

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid CHP+ Private Insurance

ID/Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL COLORADO SCHOOL BASED HEALTH CENTER CO-PAYS SND DEDUCTIBLES ARE WAIVED BY LAW!**

**Health Information Release *(OPTIONAL)***

***CONSENT TO SHARE HEALTH INFORMATION BY AND BETWEEN EAGLE COUNTY SCHOOLS (ECS)***

 I hereby consent to **release any/all ECS medical/dental records** (Power School or other records) regarding my child from ECS to the SBHC for the care and treatment of my child by the SBHC and its provider(s);

 I herby consent to **release any/all ECS special education and/or behavioral health records** (Power Schools or any other source) regarding my child from ECS to the SBHC for the care and treatment of my child by the SBHC and its provider(s);

 I herby consent to **release any/all SBHC medical/dental/ behavioral health records** regarding my child **from the SBHC to ECS** for the continued care and treatment of my child while in school at ECS or for the benefit or purpose of the following SBHC program(s), ECS/ SBHC program(s) and/or SBHC/ECS provider(s):

 Independent Education Plan In School Medication/Care /Treatment Plan Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality (HIPAA Privacy)**

I understand that the patient’s/my medical record including this information is confidential, medical record protected by HIPAA (Federal Law) and may not be shared without lawful consent of the patient or patient representative. I acknowledge that I have had the opportunity to read the HIPPA disclosure posted in the office or provided to me in a separate form **at my request** and I understand the terms and conditions of the Privacy as it applies to this/my Patient Medical Record.

**Financial Policy (*Payment is due when services are rendered.*** )

I understand that I have financial responsibility for payment of this account and if necessary applicable interest, cost of collections and attorney fees. If I choose to pay cash, payment in full may be required on the date of service. For patients’ with insurance we may collect all amounts due per policy terms to submit your insurance claims waiving any co-pay (if applicable) or any deductible not yet satisfied. We will COLLECT and/or SUBMIT per these terms for all insurance within network. If you are out of network we will COLLECT and SUBMIT for the full amount of the visit.

***Insurance Assignment, Authorization to Release Medical Information and Financial Responsibility.***

I understand that I am responsible for payment of service and hereby assign all benefits to which I am or may be entitled under any and all applicable insurance to Doctors Plus/Kids Care Clinic. I further understand that I am responsible for payment of services in the event my insurance fails to pay or provide benefits.

***This order will remain in effect until revoked in writing.***

A copy of this agreement shall be considered as an original. I understand that my medical records are confidential information hereby agree and authorize Doctors Plus/Kids Care Clinic to release all information as necessary to secure payment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature Date**