School Health Alliance
FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

ADULT PATIENT DEMOGRAPHICS **DATE OF COMPLETION** (mm/dd/yyyy): _____

Legal Name (Last, First, MI):	**Preferred Name:**	**Primary Doctor:**

Date of Birth (mm/dd/yyyy):

_____ /_____ /_____

SSN: _____-_____-_____

Race:
☐ Black/African American
☐ White
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ More than one race
☐ Unreported/Refuse to report race

Ethnicity:
☐ Hispanic ☐ Non-Hispanic

Birth Sex:
☐ Female ☐ Male ☐ Other ☐ Undefined

Sexual Orientation:
☐ Straight or Heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to answer

Gender Idenitity:
☐ Male
☐ Female
☐ Transgender Male/Trans Man/Female-to-Male
☐ Transgender Female/Trans Woman/Male-to-Female
☐ Gender Queer
☐ Additional gender category, please specify: _____
☐ Choose not to answer

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed/Widower

Home Address:	**City**	**State**	**Zip code**

Home Phone:	**Cell Phone:**	**Work Phone:**	**Email Address:**

Preferred method of communication: ☐ Postal Mail ☐ Phone ☐ Email ☐ Text

Emergency Contact 1:	**Relationship:**	**Home Phone:**	**Cell Phone:**
Emergency Contact 2:	**Relationship:**	**Home Phone:**	**Cell Phone:**

Responsible Party:	**Relationship:**	**Date of Birth** (mm/dd/yyyy):	**SSN**:
		_____ /_____ /_____	_____-_____-_____

Responsible Party Home Address:	**City**	**State**	**Zip code**

Employer/School:

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Patient Name: _____ **Date of Birth:** _____

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to comprehensive healthcare treatment, including medical care and behavioral healthcare services, that the providers and staff of the School Health Alliance (SHA) for Forsyth County and all of its affiliates. I consent to all necessary treatment of illness and injuries and preventative care, including screenings, lab work (including HIV testing), immunizations, and referrals. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that SHA employs a "team-based" approach to the delivery of healthcare and that health information may be exchanged between SHA providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment, and healthcare operations. I understand that my medical information could include medical history or information regarding diagnosis and treatment for a communicable disease (such as a sexually transmitted infection, HIV/AIDS, or hepatitis), mental illness, alcohol, or substance use. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt out by completing an Opt-out form provided by my provider. This consent is renewable annually. I may withdraw authorization for services at any time. **Initial** _____

Notice of Privacy Practice Acknowledgement:

We are required by law to provide you with our Notice of Privacy Practices, which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: on our website at https://shaforsyth.com and in our clinic locations. **Initial** _____

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to SHA and its affiliates for all charges for services provided to me unless specifically waived based on family size and income, in accordance with our billing policy. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical, and behavioral health benefits, which would otherwise be payable to me, to SHA for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, VIII, and/or XIX of the Social Security Act is correct. **Initial** _____

_____ _____

Signature of Patient or Authorized Person **Date**

INSURANCE INFORMATION

<table>
<tr><td colspan="2">Primary Insured's Name: _____
Date of Birth (mm/dd/yyyy) | SSN: _____-_____-_____
_____ /_____ /_____</td><td colspan="3">Primary Insurance Address:</td></tr>
<tr><td>Primary Insurance:</td><td>Employer:</td><td colspan="3">City:</td></tr>
<tr><td>Insurance ID Number:</td><td>Group Number:</td><td>State:</td><td>Zip Code:</td><td>Phone Number:</td></tr>
</table>

Permission to Communicate - Authorization for Release of Information

Name of Patient: _____ **Date of Birth (MM/DD/YYYY):** _____

School Health Alliance for Forsyth County is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

So that we may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, tests, lab results, and any other health information.

Describe how information will be received.	**Describe the information to be released.** Check each that can be given to person on the left in the same section.
☐ Voice Mail ☐ Mail	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other_____
☐ Other person(s): Name / Phone Number / Relationship	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other _____
☐ Email communication - Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____

☐ *For **email and/or text communication,** I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization, and my treatment will not be conditioned on signing.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt out by completing an Opt-Out form provided by my provider.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative **Date**