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

Enrollment and Consent for School-Based Health

Date of Completion: _____

Student's Legal Name (Last, First, Middle): **Date of Birth:**	Preferred Name:
Name of School:	Grade:

Student Demographics

Race:
- ☐ American Indian
- ☐ Alaska Native
- ☐ Arab
- ☐ Asian
- ☐ Black or African American
- ☐ European
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ White

Ethnicity:
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Latin American
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

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

Student lives with: (physical residence)
☐ Both Parents ☐ Parent 1 ☐ Parent 2 ☐ Self ☐ Grandparent(s) ☐ Legal Guardian

Health Care Sharing Consent:
Care Connect (access for hospital/specialist office) **Medication History** Yes: ☐ No: ☐
Yes: ☐ No: ☐

Student Phone Number: _____	**Student Birth Sex**: ☐ Female ☐ Male ☐ Other ☐ Undefined
Student Email Address: _____	**Student Social Security Number:** _____

Parent / Guardian Name:			**Insurance Subscriber Name:**		
Date of Birth: ____/____/___	Sex: ☐ Female ☐ Male	SSN: ___-___-____	Date of Birth: ____/____/_____	Sex: ☐ Female ☐ Male	SSN: ___-___-_____
Address:			Insurance Company Name: Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Cell Phone:		Phone:	Effective Date:	
E-Mail Address:	Employer Name:		Policy Number:	Group Number:	
Emergency Contact 1:	Relationship:		Guarantor Name:	Relationship to Patient:	

Do you have a medical provider? ☐ Yes ☐ No Medical Provider Name:

Do you have a dental provider? ☐ Yes ☐ No Dental Provider Name:

If you have any questions about this form, please call (336) 703-4273. You can also return completed paperwork via email to schoolhealthalliance@wakehealth.edu or in person at Mineral Springs Student Health Center 4555 Ogburn Ave Winston-Salem, NC 27105.

What services do you request? Check all that apply: ☐ Health Assessment ☐ Vaccines ☐ Sports physical ☐ Mental health ☐Sick visit/Other
Is there a CUSTODY agreement in place? ☐ Yes ☐ No **If so, list primary custodian:**
☐ Check this box if your child has no insurance coverage or insurance deductibles/co-pays**.**
Person Responsible for Payment: ☐ Mother ☐ Father ☐ Guardian or Other: _____
Preferred Method of Communication: ☐ Postal Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Web Message

Permission to Communicate

So that CRCHC may serve you better, you have the options of providing us with a list of caregivers with whom we can discuss appointments, referrals, and any other health information you desire to share. The following people may request and receive information about: ☐ Appointments ☐ Financial ☐ Treatment ☐ Referrals

Name: _____ Relation:_____ Phone: _____ Voicemail - Y or N

Name: _____ Relation:_____ Phone: _____ Voicemail - Y or N

Consent for Healthcare and Release of Personal Health Information

I voluntarily consent to comprehensive healthcare treatment including medical, nutrition, and behavioral health services for my child from the providers and staff of CRCHC, Inc. and all its affiliates (e.g., School Health Alliance for Forsyth County and Atrium Health/Wake Forest University School of Medicine/Wake Forest Baptist Health). I consent to all necessary treatment of illness and injuries and preventative care including protected information surveys and screenings as defined by NC Senate Bill 49, 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 CRCHC and its affiliates employ a "team based" approach to the delivery of healthcare and that health information may be exchanged between CRCHC and affiliate providers, staff members, and school personnel involved in my child's care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about my child for treatment, payment, and healthcare operations. If covered by Medicare or Medicaid, I certify that the information provided about my child, in applying for payment under Title's 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 my child is automatically enrolled in the Health Information Exchange, but at any time can opt-out by requesting and completing an Opt-out form provided by the provider**. I understand that North Carolina Statutes Section 90-21.5 protects a minor's right to receive services relating to sexually transmitted diseases, pregnancy, drug abuse, and emotional disturbances without parental consent. I understand that according to NC General Statutes 90-21.4 medical providers are not required to notify me about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. I further understand that CRCHC and all its affiliates will make every effort to encourage my child to discuss problems and services with me. This consent is renewable annually. I may withdraw authorization for services at any time.**

_____ _____

Parent/Guardian Signature **Date**

Notice of Privacy Practices

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: http://www.crchc.org, or by requesting one at any CRCHC Provider locations. **Initial _____**

Financial Responsibility and Assignment of Insurance Benefits

I guarantee payment to CRCH and its affiliates for all charges for services provided to me unless specifically waived based on family size and income, in accordance with the CRCHC 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 CRCHC 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 _____**

Telehealth Services

The purpose of Telehealth Services is to provide care to your child in certain situations, such as when they become ill at school or during periods of school closure. By signing below, you are acknowledging that you understand the risk sand benefits of your child receiving treatment through school-based health service and you give consent for us to treat your child, virtually by telehealth. Telehealth is the use of electronic information and communication technologies by a health care provider (using interactive audio, video, or data communications) to deliver services to your child when he/she is at school (or out of school) and the provider is located at a different place. Not every condition can be treated by telehealth. If your child's treatment provider believes your child would be better served by in person treatment you will be notified and referred to an in person setting for further care. If your child's condition is determined to be emergent, the school and/or the provider may send him/her to the hospital. Telehealth encounters are subject to the requirements of the HIPAA privacy rule that apply to protected health information (outlined in the release of information section). If you text or email us with patient information in an unsecured manner, you understand that the patient information could be viewed by someone other than us. There is a risk that treatment provided using telehealth could be disrupted due to technical failures.

For telehealth services occurring via Athena, if your child is under the age of 12, you will maintain the primary account for your child. If your child is over the age of 12 (N.C. Gen. Stat. § 90-21.4), your child will maintain the primary account and you may receive proxy privileges to the account. **Initial _____**

Screening Tools

I understand that the protected information surveys and screening tools, risk assessments, and questionnaires that may be used with students and their families are available for review at any time on our website at shaforsyth.com under "Our Screening Tools." I also understand that it is my responsibility to review these in advance of my child's appointment with their provider, and that I am encouraged to talk with my child's provider should I have any questions about the protected information surveys, screening tools, risk assessments, and questionnaires prior to my child's appointment.

_____ _____

Parent/Guardian Signature **Date**

School Based Health Center Sliding Scale Application

Student Name: _____ Student's Date of Birth: _____
Last First Middle (mm/dd/yyyy)

Parent/Guardian Name: _____
Last First Middle

Every student can complete the Sliding Scale Application, regardless of insurance status. This application serves to help determine if there is any discounted rate for services. **No enrolled student will be denied services because of inability to pay.** Fees are based on family income and insurance plan guidelines. Families without insurance will be charged according to the following sliding fee scale based on the Federal Poverty Level (FPL)*. Families must provide their total family income and the number of people in the household based on the Definition of Family for purposes of Kintegra billing. **The signature below the income and household information provided certifies all information is true and correct to the best of the responsible party's knowledge.** Parents or students are responsible for copayments, deductibles and payment for services not covered by insurance. Families may request an explanation or reconsideration of a billing issue by contacting the CRCHC Billing Department at (704) 792 2251

FPL	0-100%	101-150%	151 - 200%	201% +
Nominal Fee	$0	$0	$50	Full Charge

*** Out of pocket maximum for students is $100.00 per month.***

PLEASE PROVIDE THE FOLLOWING INFORMATION, AND SIGN THE BOTTOM OF THE FORM IN ORDER TO BE CONSIDERED FOR ANY ASSISTANCE IN PAYMENT OF SERVICES

ALL INFORMATION REMAINS CONFIDENTIAL

1. Estimated Income for Family — Count regular gross income of self, parents, stepparents, legal guardian(s), and other income such as child support, alimony, and retirement/disability benefit income.	**$_____weekly** **$_____monthly** **$_____yearly**
2. Number of People in Household — Including self, mother, father, legal guardian(s), stepparents, brothers, sisters, half-brothers, half-sisters, stepbrothers, and stepsisters.	**Total # of People**

Based on the number of family members in your household, and your total family income, the health center will determine if your child will:

- receive services without charge.
- receive services to be billed to you at $50, with maximum out of pocket plans.
- receive services to be billed to you at 100% of established rates, with maximum out of pocket plans.

You will be informed by phone or mail, if it is determined that your child's health center visits will result in billed charges.

_____ _____

Parent/Guardian Signature **Date**

Release of Information To and From the School Health Alliance for Forsyth County

I, _____ _____

Student's Parent/Legal Guardian Name | Relationship to Student

Authorize:

Winston/Salem/Forsyth County Schools
P.O. Box 2513
Winston-Salem, NC 27102-2513

To disclose to and exchange:

School Health Alliance for Forsyth County
2000 West 1st Street, Suite 308
Winston-Salem, NC 27104

Regarding:

Student's Name	Student's DOB	Telephone Number	
Student's Address	City		State
Student's School ID # (Lunch Number):			

The following protected information:

- School/Education Records (including, but not limited to, attendance records, grade reports, psychoeducational test records, special education records, discipline records, End of Grade (EOG) AND End of Course (EOC) test scores, Student Assistance Team records, enrollment, promotion/retention, and classroom performance and behavior over time
- Mental Health Records (i.e., appointment attendance, diagnoses, treatment plans)
- Other: _____

Agreement to Information release for Research Purposes: Please circle Yes or No. Yes No

I authorize School Health Alliance to disclose my student's participation, and/or other program information collected, with The Data Sharing Project team for research purposes. I understand this information will never be published in a way that will lead to the identification of my student and will be used to improve SHA services over time. This information will be used for the purpose of coordinating and providing health/mental health care for the students as well as for providing support to the students. **This authorization shall be in effect for 12 months from the initial date of request unless otherwise noted below.**

STUDENT'S RIGHTS AND AUTHORIZED SIGNATURE:

- I have the right to revoke this authorization at any time by completing a revocation form and returning it to a CRCHC/ SHA staff member.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where 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 that the student's treatment/academics, payment, or eligibility for benefits will not be conditioned on signing.
- I understand that released information may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or HIV).

Parent/Guardian Signature: _____ Date: _____