Upstate Family Health Center, Inc.

School-Based Health Centers

Dear Parents/Guardians:

Upstate Family Health Canter (UFHC), in collaboration with the Utica City School District, have established three School Based Health Centers (SBHC) in Utica. They are at Donovan Middle School, Kernan Elementary School, and Martin Luther King Elementary School. In Waterville, we are located within The Junior/Senior High School and Memorial Park Elementary School. An SBHC provides primary care and preventative health care services in school to those enrolled in the program. These services include:

- Complete physical examinations
- Vision, hearing, and scoliosis screenings
- Immunizations, Flu vaccines
- Diagnosis and treatment of both short term and long term illnesses
- Health education and wellness promotion
- Mental health screenings and referrals

All students are eligible to enroll in the School Based Health Center. We do not replace the student's primary care doctor, we work with them. There are no out of pocket expenses for any service provided by the SBHC. The SBHC will bill the students' insurance. If your child does not have health insurance coverage, or your health insurance does not cover SBHC visits, there will be NO CHARGE. If you do not have health insurance coverage for your child and are interested in how you can receive information on free or low cost insurance, please call the SBHC, or contact Upstate Family Health Center at (315) 624-9470.

If you wish to enroll your child in a SBHC, please complete the enclosed SBHC enrollment forms, and return them to the School Based Health Center as soon as possible.

- Student Enrollment Form
- Health History Form
- Information Authorization Form
- Acknowledgement Form

Please feel free to contact the SBHC with any questions.

We are excited about working with you and your children and look forward to a healthy and productive year.

Sincerely,

The School Based Health Center Staff

Donovan Middle School 1701

Noyes Street, Utica

(315) 368-6593

Waterville Jr./Sr. High

381 Madison St. Waterville

315-841-3857

Kernan Elementary 929

York Street, Utica

(315)368-6777

Memorial Park

Elementary 145 East

Bacon St Waterville

315-841-3715

MLK Elementary

211 Square Street, Utica

(315)368-6730

Upstate Family Health Center, Inc.

SCHOOL BASED HEALTH CENTER

ENROLLMENT FORM

Student Name			Date of Birth	Sex ◯Female ◯Male	
Phone Number	Cell Number		Social Security		
Address	Apt	City	State	Zip	Country
Mother's Name:		Father's Name:			
Mother's Date of Birth:	Mother's Maiden Name		Father's Date of Birth:		
Legal Guardian: ◯Dad ◯Mom ◯Shared ◯Other (Explain)					
Emergency Contact Name:	Relationship to Student:		Phone Number		

Please check only one box below which best fits your needs

❑ My child regularly goes to another doctor or clinic for health care. I would like the school based health center to work with my child's doctor/clinic to keep my child healthy Doctor's name and address: _____

❑ My child does not have a regular doctor or clinic. I would like the school based health center to provide health care as necessary to keep my child healthy.

CONSENT TO TREAT - PLEASE READ AND SIGN BELOW.

I GIVE CONSENT FOR MY CHILD TO RECEIVE HEALTH CARE SERVICES PROVIDED BY THE STAFF AT THE SCHOOL BASED HEALTH CENTER. I UNDERSTAND THAT I MAY OR MAY NOT BE PRESENT FOR MY CHILD'S MEDICAL APPOINTMENT. THE STAFF OF THE SCHOOL-BASED HEALTH CENTER CONSIDERS PARENTAL INVOLVEMENT VERY IMPORTANT. IN ORDER TO PROVIDE OPTIMAL HEALTH CARE TO YOUR CHILD, IT MAY BE NECESSARY FOR THE SCHOOL BASED HEALTH CENTER STAFF AND SCHOOL NURSE TO REGULARLY COMMUNICATE AND SHARE MEDICAL AND HEALTH RELATED INFORMATION.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

HEALTH INSURANCE INFORMATION

Is student covered by health insurance? ◯ Yes ◯ No

Primary Insurance & Address			Policy #
Name of Policy Holder:	Date of Birth		SSN
Employer of Policy Holder:	Relationship of Patient to Insured:		
Secondary Insurance & Address			Policy #
Name of Policy Holder:	Date of Birth		SSN
Employer of Policy Holder:	Relationship of Patient to Insured:		

MY INSURANCE COVERS IMMUNIZATIONS. ◯Yes ◯No

BILLING CONSENT - INSURANCE AUTHORIZATION AND ASSIGNMENT

***ASSIGNMENT AND RELEASE*: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO UPSTATE FAMILY HEALTH CENTER. I ALSO AUTHORIZE UPSTATE FAMILY HEALTH CENTER TO RELEASE ANY INFORMATION REQUESTED BY INSURANCE COMPANIES INCLUDING MEDICAL, SURGICAL, DRUG, ALCOHOL, AND/OR PSYCHIATRIC INFORMATION. RELEASE OF HIV/AIDS INFORMATION MAY REQUIRE FURTHER AUTHORIZATION.**

_____ _____

SIGNATURE OF PARENT/GUARDIAN ***DATE***

Upstate Family Health Center, Inc.

SCHOOL-BASED HEALTH CENTER

HEALTH HISTORY

Child's Name	**DOB**	**Date**

Allergies (Food, Medication, Environmental) **Reaction**

_____ _____

_____ _____

_____ _____

Current Medications (include vitamins/fluoride/supplements):

1. _____ Prescribed by: _____
2. _____ Prescribed by: _____
3. _____ Prescribed by: _____

List hospitalizations, illnesses, accidents, broken bones, surgeries etc.

Date Child's Age Explanation

_____ _____ _____

_____ _____ _____

_____ _____

Date of last physical exam: _____ By Whom: _____

Date of last dental exam: _____ By Whom: _____

Pharmacy Name: _____ Location: _____

Family History – Check any of the following conditions affecting the child's relatives (including aunts, uncles, cousins, grandparents).

	Mother	Father	Siblings	Grandmother	Grandfather	Aunts/Uncles
Diabetes	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑
Sickle Cell Anemia	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Seizure Disorder	❑	❑	❑	❑	❑	❑
Kidney Problems	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Alcohol/Drug Problems	❑	❑	❑	❑	❑	❑

Upstate Family Health Center SBHCs offer mental health services through counselors at school. Would you like to receive more information on counseling services for your child? ◯Yes ◯No

Upstate Family Health Center, Inc.

SCHOOL-BASED HEALTH CENTER
HEALTH HISTORY

Child's Name	DOB	Date

Indicate which of the following conditions or problems this child has ever had:

Condition	Date/Explain	Condition	Date/Explain
☐ Skin trouble		☐ Rheumatic fever	
☐ Eye problems		☐ Chicken pox	
☐ Frequent ear infections		☐ Joint aches or pain	
☐ Difficulty hearing		☐ Loss of consciousness	
☐ Frequent nose bleeds		☐ Painful periods	
☐ Frequent sore throats		☐ Anemia	
☐ Pneumonia		☐ Teeth/Dental Problems	
☐ Asthma		☐ Bedwetting	
☐ Heart murmur		☐ Painful urination	
☐ Jaundice		☐ Kidney or bladder infection	
☐ Frequent stomach aches		☐ Black stool	
☐ Frequent diarrhea		☐ Constipation	
☐ Speech problems		☐ Bad Temper	
☐ Slow learner		☐ Miserable/withdrawn	
☐ Doesn't pay attention		☐ Overactive	
☐ Won't mind		☐ Other	
☐ Mental Health Issues			

Social History

Do you have any concerns (behavioral, emotional, or otherwise) about this child? If yes, please explain.

Please list any specialist your child sees (Physician Specialist, Counselor, or Speech, Physical or Occupational Therapist)

Any history or sexual/physical/emotional abuse? (Please explain) _____

Indicate any financial, interpersonal, or family problems you are worried about: _____

What does your child do in spare time (hobbies/sports)? _____

TV hours daily?_____ Computer hours daily?_____ Video games hour daily? _____

How is he/she doing in school? _____ Does he/she have good friends? _____

Are you concerned that your child may be exposed to weapons or violence? _____

Are you concerned about your child using alcohol, drugs or tobacco? _____

Reviewed by:	Date

Upstate Family Health Center, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Patient Address
Date of Birth	Social Security Number

I authorize Upstate Family Health Center, Inc (including School Based Health Centers)

❑ TO **RELEASE** the above named individual's health information to:	❑ To **OBTAIN** the above named individual's health information from: *Dr.'s Name:*

I understand that:

1. This authorization may include disclosure of information relation **to ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only If I place my initials on the appropriate line in item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 9(a), I specifically authorize release of such information to the person(s) indicated in item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV- related information, I may contact the New York State Division of Human Rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be disclosed by the recipient (except as noted above in item 2), and this disclosure may no longer be protected by federal or state law.

6. Name and address of health care provider or entity to release this information: _____

7. Name and address of the person(s) or category of person to whom this information will be sent: Upstate Family Health Center, Inc. School Based Health Center. PLEASE INDICATE WHICH SCHOOL YOUR CHILD IS ATTENDING: ❑ **Kernan**, 929 York Street, Utica NY 13502, Fax: 315-223-4463 ❑ **MLK** 211 Square Street, Utica NY 13501 Fax: 315-368-6734 ❑ **Donovan** 1701 Noyes Street, Utica NY 13502 Fax: 315-223-4464 ❑ **Memorial Park Elementary** 145 E. Bacon St Waterville, NY 13480 315-841-3723 ❑ **Waterville Jr./Sr. High School** 381 Madison St. Waterville, NY 13480 Fax: 315-841-3832

   (a). Specific information to be released:Most recent office note/physical, vaccine record

   ❑ Medical Record from (insert date)_____to (insert date)
   ❑ Entire Medical Record, Including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers
   ❑ Other:_____Include: (indicate by initialing):_____**Alcohol/Drug Treatment**
   _____ **Mental Health Information**
   _____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ____ By initialing here_____I authorized_____
Initials Name of individual health care provider

To discuss my health information with my attorney, or a government agency, listed here: _____
(Attorney/Firm Name or Governmental Agency Name)

9. Reason for release of information:
   ❒ At request of individual ❑ Other

10. If not the patient, name of person signing the form:

11. Date or event on which this authorization will expire: NONE	12. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law.	Date

Upstate Family Health Center, Inc.

HealtheConnections®

Authorization for Access to Patient Information
New York State Department of Health
Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Upstate Family Health Center, Inc.

SCHOOL BASED HEALTH CENTER

ACKNOWLEDGEMENTS FORM

NAME:_____ Date of Birth: _____
(please print)

I HAVE RECEIVED A COPY OF THE FOLLOWING:

1. Patient Bill of Rights/ Grievance Process
2. Privacy Commitment Notice (HIPAA)

_____ _____
Patient/Guardian Signature Date

_____ _____
Authorized Individual and Relationship to Patient Date

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK YOUR HEALTH CARE PROVIDER

SCHOOL BASED HEALTH CENTER AT
PATIENT'S BILL OF RIGHTS

As an individual receiving services through a School-Based Health Center, a service of Upstate Family Health Center, you have the right, consistent with law, to:

- Understand and use these rights. If for any reason you do not understand or you need help, the clinic MUST provide assistance, including an interpreter.
- Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- Receive emergency care if you need it.
- Be informed of the name and position of the doctor who will be in charge of your care in the clinic.
- Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.
- Receive complete information about your diagnosis, treatment and prognosis.
- Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders—A guide for Patients and Families."
- Refuse treatment and be told what effect this may have on your health.
- Refuse to take part in research. In deciding whether to participate, you have the right to a full explanation.
- Privacy while in the clinic and confidentiality of all information and records regarding your care.
- Participate in all decisions about your treatment.
- Review you medical record without charge. Obtain a copy of your medical record for which the clinic can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
- Receive an itemized bill and explanation of all charges.
- Complain without fear of reprisals about the care and services you are receiving. If you are not satisfied with clinic's response, you can complain to the New York State Health Department. The clinic must provide you with the Health Department telephone number.
- Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy.

If you have any questions or concerns regarding these rights, or wish to voice a grievance, you are invited to contact:

The Executive Director/CEO
Upstate Family Health Center, Inc.
1001 Noyes Street
Utica, NY 13502
Phone: (315) 724-6907

NYS DEPARTMENT OF HEALTH
Human Rights Division
Syracuse Regional Office
333 E. Washington Street
Syracuse, NY 13202
Phone: (315) 428-4633