PATIENT INFORMATION-SCHOOL CLINIC

Please complete both sides and sign back of form*

☐ **Hawthorne** ☐ **Hayward** ☐ **Terry Redlin**

Would you like your child seen at the School-Based Clinic?

I want my child to get medical services at Falls Community Health. ☐ Yes ☐ No

I want my child to get dental services at Falls Community Health. ☐ Yes ☐ No

My child can be transported to the FCH main site at 521 North Main Avenue if necessary. ☐ Yes ☐ No

Authorization is valid until child no longer attends school they enrolled in.

Patient Information:

Patient Name: _____
Last First Middle Initial

Date of Birth: _____ Mother: _____ Father: _____

Gender: ☐ Male ☐ Female Social Security Number: _____ Grade _____

Address: _____
Street Apt. No. City State Zip

Phone Number: _____ (Home) _____ (Cell) Email Address: _____

Emergency Contact Name: _____ Emergency Contact No. _____

List any medical or behavioral problems: _____

List any medications: _____

Where would you like your prescriptions called to? _____

List any allergies: _____

Insurance:

Responsible Party: _____
(Head of Household/Guarantor) Last First Middle Initial Date of Birth

Medicaid/Insurance ☐ Yes ☐ No Policy No.: _____ Group No.: _____

Policy Holder Name: _____ Date of Birth: _____

Dental Insurance ☐ Yes ☐ No Policy No.: _____ Group No.: _____

Policy Holder Name: _____ Date of Birth: _____

You may be eligible for a discount on services based on your household income.
Please contact the Billing Office for more information on how to apply.

Sign back of form*

Additional Information:

Do you speak English? ☐ Yes ☐ No If **No**, what language do you speak? _____

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black
☐ Native Hawaiian
☐ Hispanic or Latino (all races)
☐ Other Pacific Islander
☐ White (not Hispanic or Latino)
☐ Other (please specify): _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Do you have a permanent home (house, apartment, etc.)? ☐ Yes ☐ No

If no, where did you spend last night? ☐ Shelter ☐ Street ☐ Friends/Relatives ☐ Other: _____

Financial Responsibility and Assignment of Payer Benefits

I agree that I am financially responsible for all charges related to services provided by Falls Community Health (FCH). I agree FCH will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. I give my authorization for FCH to filing of a claim and request for direct payment of benefits to FCH.

Consent to Treatment-Sharing of Information from FCH

I consent to exams, treatments, diagnostic tests, and medications that any provider at FCH feels is necessary for the health of my child.

I acknowledge that no guarantees have been made to me and I am aware that I have the right to ask my provider or nurse questions regarding my child's treatment or exam.

I authorize FCH to disclose my child's confidential information only for treatment, payments, or health care operations. FCH may share clinical information with the Sioux Falls School District to coordinate care.

I give consent to nursing assessment, health supervision, immunizations, and release of information as indicated to the Sioux Falls School District.

Notice of Privacy Practices-I have been offered a copy of this office's Notice of Privacy Practices.

Sharing of Information from School District

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students' personal information held by educational agencies or institutions.

I give the Sioux Falls School District permission to share personally identifiable student information with Falls Community Health. This information will only be used to coordinate care with FCH. The information shared will be limited to demographic, insurance status, and health history.

Authorization

Signature of Parent or Authorized Person	Print Name/Relationship	Date