PATIENT REGISTRATION & CONSENT FOR SBHC SERVICES

La Clinica Del Pueblo
SCHOOL BASED HEALTH CENTER

FY 18-19

STUDENT INFORMATION

Student Name (last, first, middle)	Date of Birth	Social Security Number	Grade
Patient Address (street, city, state, and zip)	Patient Phone - home Patient Phone - Cell		
Parent(s)/Legal Guardian(s) Name(s)	Patient Sex ☐ Male ☐ Female Patient Race ☐ Black ☐ White ☐ Native American/Alaska Native ☐ Hispanic ☐ Other		
Parent(s)/Legal Guardian(s) Address (street, city, state and zip)	Home Phone Work Phone Cell Phone Numbers		
Emergency Contact Person Name and Relationship to Patient	Emergency Phone		

INSURANCE INFORMATION

Primary Care Giver:	Dental Care Provider/ Last Visit Date
Medical Insurance: Policy Number: Name of Policy Holder: Relationship to Patient:	Dental Insurance: Policy Number: Name of Policy Holder: Relationship to Patient:

If Medicaid coverage, please check type:

☐ Blue Cross/Blue Shield Cent. ☐ Lovelace ☐ Molina ☐ Presbyterian Cent. Full Medicaid

I give **Permission** for SBHC Staff to Administer the following Over the Counter Medecines. PLEASE INITIAL

_____TYLENOL _____TUMS _____ALLERGY MEDS _____IBUPROFEN _____MYLANTA _____DECONGESTANTS

List Any Allergies	List any surgeries When/Where	List Hospitalizations When/Where	List of Current Medications

CONSENT FOR SERVICES

Check here if you **do not** want your child to participate in: _____**Dental Screening** _____ **BMI Screening**

I give permission for my child, named above, to receive SBHC services while he/she is enrolled in this school and for SBHC staff to access my child's class schedule (for appointment purposes only). I understand that SBHC services are confidential, except in a life-threatening situation or when emergency services are needed and in accordance with the law. I give permission to the SBHC to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as for maintaining quality and safety. I understand that SBHC health records are confidential and will not be shared unless written consent is provided by the student and/or parent/guardian. I have received a copy of the the HIPAA Notice of Privacy Practices. I understand that New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. **Unless I choose to withdraw my consent in writing, this authorization will continue for the entire period of time my child is enrolled in this school.**

Signature of Parent/Guardian	Date
Signature of patient, if 18 years or older	Date

Revised March 2013

"Please Complete Other Side"

LA CLINICA DEL PUEBLO
PO Box 250, Tierra Amarilla, NM 87575

Please initial next to each section that applies:

Patient Name_____Social Security #_____DOB:_____

_____**CONSENT FOR TREATMENT:** I authorize the employees, agents and staff of La Clinca del Pueblo to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician be necessary.

_____**NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

_____**FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for all charges, whether or not paid by insurance La Clinca del Pueblo does not participate in **every** insurance plan. I understand that I am responsible for verifying that my LCDP provider is a participating provider in my insurance plan. Payment is expected at time of service.

_____**RELEASE OF INFORMATION:** I authorize the clinic to release any and all patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by La Clinca del Pueblo. I consent to use and disclosure of my protected health information to carry out treatment, payment or health care operations by La Clinca del Pueblo.

_____**SLIDING FEE SCALE:** Qualifying for our sliding fee scale based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information from you. **If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.** We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of this determination. If you do not pay for services at the time they are rendered, your balance must be paid in full within sixty (60) days.

_____**MEDICARE /MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf for any services furnished by or in the clinic, including physician services. I authorize any holder of medical or other information about me, to release to La Clinica del Pueblo for Medicare and Medicaid Services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to submit claim to Medicare and/or Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

_____**ACKNOWLEDGEMENT:** I acknowledge receipt of La Clinica del Pueblo's Notice of Privacy Practices (HIPAA) and I also acknowledge receipt of the Behavioral Health Addendum if I am receiving behavioral health services .

_____**CERTIFICATION AND** I certify that all foregoing information and all information supplied by me, as part of the registration process is correct.

_____ _____
Patient or Parent/Legal Guardian **Date**

_____ _____
Relationship to Patient **Witness Signature**

_____ _____
Staff Signature **Date**