First Choice Health Centers
For All Your Health Care Needs

School Based Health & Dental Program
Registration and Consent form

School Name: **Grade:**

Dear Parent or Guardian: Our School Based Healthcare Program is pleased to provide the following services at your child's school during school hours: medical, behavioral health, dental cleaning, fluoride treatment, oral health education, sealant placement & restorative care (if needed). Please fill out this form and return to school with your child to enroll in the program. Questions? Call our Coordinator at 860-610-6183.

Student Information

Last Name | First Name | MI | Date of Birth

Street Address | City | State | Zip | Social Security Number

Public Housing ☐ Homeless ☐ If yes, please specify: Shelter ☐ Street ☐ Doubling Up ☐ Transitional ☐ Other ☐

Home Phone	C ell Phone	Work Phone	Emergency Contact Person	Emergency Contact Number

Sex: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Russian ☐ French ☐ Indian ☐ Other _____

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

Race: ☐ Black ☐ White ☐ Asian ☐ American Indan/Alaskan Native ☐ Pacific Islander ☐ Other Pacific Native ☐ Native Hawaiian ☐ Other: _____ ☐ Unreported or Refuse to Report

Parent/Guardian Name | Parent/Guardian Date of Birth

Insurance Information

Primary Dental Insurance	Insurance ID/Medicaid ID #	Group #
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's Social Security #
Primary Medical Insurance	Insurance ID/Medicaid ID #	Group #
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's Social Security #

Income

My Annual Income is: Total # of Dependents in Household (including patient):

Last Dental Visit

When was your child's last dental visit? Where?

Permission for Treatment, Payment and Operations

I give permission for my child to receive medical, dental and behavioral health treatment/services by First Choice Health Centers, Inc. **I understand that this authorization is valid as long as my child is enrolled in the school district listed above** or until I revoke this authorization with the Program Coordinator at First Choice. I hereby authorize First Choice to use and disclose my child's medical/dental information for treatment, payment and healthcare operation purposes. My consent includes the release of such information to process claims to my insurance company. I authorize direct payment from my insurance company to First Choice. I also allow disclosure of protected health information between the school nurse as appropriate. I consent to receiving phone calls regarding services my child receives or may be eligible to receive. I acknowledge that I have received a copy of the Notice for Privacy Practices for First Choice Health Centers, Inc., which further explains how First Choice may use and disclose my Protected Health Information. By signing this consent form I certify I am the legal guardian and legal custodian of the student named above. I have read and understand the above and agree with the above paragraph and certify that all the information provided is true and complete.

Signature: Date:

I certify and attest that all of the above information is true and correct. I understand that FCHC may verify information on this form. I understand that the financial information will determine eligibility for the center's sliding fee discount. I also understand that if I intentionally misrepresent my family's income, my child will not be eligible to receive services at a discount rate. I understand that if my child is uninsured, my fee will be based on a sliding fee schedule. I also understand that I will be financially responsible for all charges incurred.

Signature: Date:

Any information release by provider to authorized persons is subject to the following notices:
Drug and Alcohol Abuse Information:
In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:
This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rule prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol and drug abuse patient.
HIV-Related Information
In the event that information released constitutes confidential HIV-Related information protected under Connecticut Law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.