Family Health Centers

Care for your Health & Wellness

Family Health Centers - Iroquois High School

Tel: (502) 380-5201

4615 Taylor Blvd, Louisville, KY 40215

www.fhclouisville.org

High Quality Care Where Everyone is Welcome

School Based Clinic Consent Packet

There is a Family Health Centers Clinic located in your child's school!
We offer many integrated services including:

Sick Visits	Physical Exams
Sports Physicals	Immunizations
ADHD Services	Behavioral Health Services

To Sign Up

- ☐ **Sign and return the attached forms to your child's teacher or the clinic.**
- ☐ Fill out the insurance section OR send a copy of child's insurance card.
- ☐ Sign *Proof of Income for Sliding-Fee Discounts* and return proof of income to your child's teacher or the clinic.

Family Health Centers School Based Clinics accept all types of insurance including Medicaid.

If you or your child does not have insurance, we can help. Call Family Health Centers Outreach and Enrollment today at (502) 772-8182 to find out if you or your family qualifies for Medicaid, KCHIP, or other affordable health insurance options.

You can also talk to your school clinic staff about insurance questions or discounted services.

Family Health Centers School Based Clinics will provide services regardless of your ability to pay and is prepared to become your students' medical home if needed.

(Created 1/26/2024)

Family Health Centers

Care for your Health & Wellness

Name of Patient: _____ **Date of Birth: _____**

Consent to Treat

Permission to Treatment is hereby granted to any healthcare provider employed or subcontracted by Family Health Centers, Inc. (FHC), to render such medical and minor surgical treatment as deemed necessary. This permission includes, but is not limited to testing, diagnosing, and treating HIV and other blood borne infections, sexually transmitted diseases (STDs), Substance Abuse, and Mental Health.

Authorization to Release Information is given to FHC for the purposes of Treatment, Payment, and Health Care Operations. This authorization allows FHC to release protected health information (PHI) to the extent necessary to determine payment, including special programs . This authorization allows FHC to release/share information for the purposes of internal or external audits to ensure compliance with Federal, State, local laws, regulatory agencies, and special programs. FHC is authorized to release my information to other health care providers to ensure continuity in my care.

FHC participates in an effort called Health Information Exchanges (HIE) . Health Information Exchanges allows FHC to share and retrieve your health information with other health care providers. FHC currently participates with both a State and National HIE, Kentucky Health Information Exchange (KHIE) and CommonWell, and Care Quality.

Assignment of Benefits: I authorize the payment of benefits for services provided to me by FHC, to be paid directly to FHC, for any services furnished. This authorization for payment remains in effect for one year from the date of signature regardless of changes in payer source.

Acknowledgement of Receipt: I acknowledge that I was provided FHC's Patient Handbook, which includes FHC's Financial Policy and detailed description of the uses and disclosures allowed by this consent, as well as other rights that I have regarding my protected health information.

Expiration: This consent expires 1 year from date of signature unless otherwise revoked by you.

_____ _____

Signature of Patient, Parent, or Legal Representative Date:

_____

Relationship to patient

Family Health Centers
Care for your Health & Wellness

Proof of Income for Sliding-Fee Discounts

Family Health Centers (FHC) provides discounts on our services based on your household size and income. These **sliding-fee discounts** can make your healthcare and prescriptions more affordable. To get FHC's sliding-fee discounts, you must show proof of income within **30 days** of your first visit. The following items are proof of income that FHC is able to accept. Choose one of these items to bring in.

Current Pay Stubs for the most recent one month of work of everyone working in your household. 4 pay stubs if paid weekly, or 2 pay stubs if paid every other week. This can include unemployment pay-stubs.	**Letter from an organization that helps you, like a Church, stating your situation related to your income.** Letters must be on letterhead, signed, with the name and telephone number of the person writing the letter.	**Letter from your employer that provides your income amount.** Letters can be on letterhead or handwritten, they must be signed, with the name and telephone number of the person writing the letter. **The letter must include your pay rate and the number of hours worked each week.**
Letter for Social Security, SSI, Disability, Unemployment, Food Stamps or other public assistance that shows your income. Only 1 letter is needed.	**Most recent income tax filed or W2 from your employer.**	 ***Only one proof of income document is needed.***

Proof of income can be brought to any FHC location that is convenient to you. If you have dependents that will also use FHC services, please let the receptionist know so t their sliding-discount can set at the same time.

Your discounts are based on the Federal Poverty Limits (FPL). You can expect the following discount once your sliding-discount is determined:

SLIDE A	B	C	D	E	F
100% FPL	101%- 125% FPL	126-150% FPL	151-175%	176-200%	More than 200% FPL
$20/Medical visit $30/Dental visit	Pay 20% of total bill.	Pay 40% of total bill.	Pay 60% of total bill.	Pay 80% of total bill.	No Discount.

I understand that if FHC does not receive my proof of income within 30 days, I will be set to a SLIDE F and NOT receive discounts on services.

_____ _____

Patient Signature Date

School Based Clinic Registration Form

School/Teacher:_____

PATIENT INFORMATION (PLEASE PRINT)					
Last Name: **First Name:** **Middle:**			**Date of Birth:**	**Social Security Number:**	**Sex:** ❑F❑ M
Home Phone Number:	Address:		City:	State:	Zip Code:
PARENT/GUARDIAN					
Guardian #1 Last Name:	Guardian #1 First Name:		Relationship to Student: ❑Parent ❑Guardian ❑Stepparent ❑Other ❑Foster Parent	Guardian lives with student? ❑Yes ❑No	Sex: ❑ F❑M
Cell Phone:	Work Phone:		Email:	Date of Birth:	
Guardian#2 Last Name:	Guardian #2 First Name:		Relationship to Student: ❑Parent ❑Guardian ❑Stepparent ❑Other ❑Foster Parent	Guardian lives with student? ❑ Yes ❑ No	Sex: ❑ F❑M
Cell Phone:	Work Phone:		Email:	Date of Birth:	
Emergency Contact other than parent:	Emergency Contact Phone Number:		Relationship to Child:	Race: ❑White ❑ African American ❑Asian ❑Native American or Alaskan ❑Native Hawaiian or Pacific Islander	
How many people live in your home?	(Required) Total Yearly Income:		Language:	Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino	
What is your housing situation today? ❑I have housing ❑I choose not to answer this question		❑ I do not have housing (staying with others, in a hotel, shelter, living outside on the street, in a car, or in a park)			
Are you worried about losing your housing? ❑Yes ❑No ❑I choose not to answer this question					
Does your child attend Jefferson County Public School? ❑Yes ❑No					
What Pharmacy do you use?_____Street: _____ **Would you prefer to use the FHC Pharmacy located at 4112 Taylor Blvd, Louisville KY 40215? ❑Yes ❑No**					
MEDICAL INSURANCE INFORMATION: If you have a Medical Card, KCHIP Card or private insurance, please complete the information below. The insurance information can be found on the front/back of your insurance card.					
Insurance Company Name or MCO:	Medical Card Number/ID/Policy Number:		Group Number:		
Policy Holder's Name:	Policy Holder's Date of Birth: (Required)		Relationship to patient:		
DENTAL INSURANCE INFORMATION: If you have separate Dental Insurance, please complete the information below. The insurance information can be found on the front/back of your insurance card.					
Insurance Company Name or MCO:	Medical Card Number/ID/Policy Number:		Group Number:		
Policy Holder's Name:	Policy Holders Date of Birth: (Required)		Relationship to patient:		
I do agree that the completed information is true to the best of my knowledge. I also understand that by signing this form, I acknowledge that I have access to a copy of Patient Rights & Responsibilities and Family Health Centers' Privacy Notice provided at the Clinic or I may look it up on https://www.fhclouisville.org/get-health-care/for-patients/patients-rights/					
Signature of Parent or Guardian WHO HAS LEGAL CUSTODY OF THE CHILD: X			Date: X		
Printed Name:					

Family Health Centers

Label
Or
Patient Name: _____
DOB: _____
Chart Number: _____

CONSENT FOR TREATMENT/PROXY

Permission is hereby given to the staff of Family Health Centers (FHC) to render treatment to the above named patient whose relationship to me is Self _____ Child _____ Spouse _____ Other (specify) _____

_____ _____
Signature Relationship

NOTE: If signed by someone other than the patient, we need written proof of your authority to act on the behalf of the patient.

Name:	Phone Number:	Phone Number:	Relationship

Authorization: This authorization allows Family Health Centers (FHC) to share tests results, and information regarding your condition and/or treatment, including (please initial applicable line): ____ HIV (AIDS virus); _ sexually transmitted diseases; _____ behavioral health; or _____ drug and/or alcohol abuse, with the individuals listed above. This authorization is NOT sufficient to disclose copies of the actual health record. ***NOTE*** this authorization does NOT give the above listed individual(s) permission to update any information on your patient account including updating consent for treatment and/or authorizations.

Conditions: I acknowledge that FHC is not requiring me to sign this authorization in order to receive treatment and/or services.

Revocation: You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. You must submit the request for revocation in writing to FHC's Privacy Officer. When we receive your revocation, we will immediately stop using or disclosing the Health Information in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Expiration: This authorization shall expire one (1) year from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you.

By signing below, you acknowledge receipt of a signed copy of this authorization.

_____ _____
Printed Name Date

_____ _____
Signature Relationship

_____
Witness Signature

NOTE: If signed by someone other than the patient, we need written proof of your authority to act on the behalf of the patient.

Family Health Centers

Label or
Patient Name: _____
DOB: _____
Chart Number: _____

PERMISSION TO ALLOW VERBAL ACCESS TO MY PROTECTED HEALTH INFORMATION

I allow Family Health Centers to talk about my protected health information with the following people:

Name:	Phone Number:	Phone Number:	Relationship:

Authorization: This signed form allows Family Health Centers (FHC) to tell the people listed above information about my appointments, health condition, treatment, and test results. This includes information about (please initial):

_____ HIV/AIDS status
_____ Sexually transmitted diseases
_____ Behavioral health
_____ Drug and/or alcohol abuse.

**This does NOT mean that copies of my health record can be shared with the people listed above.

**This does NOT allow the people listed above to update my account, update consent for treatment, or change any authorizations.

Conditions: I understand FHC does NOT require me to sign this form to receive treatment or services.

Revocation: I have the right to cancel this authorization at any time, according to FHC's Notice of Privacy Practices. To do so, I must make a written request to FHC's Privacy Officer. FHC will stop sharing my health information with the people listed above as soon as they receive my request. My cancellation cannot cover health information FHC shared before I made my request.

Expiration: This authorization will end one (1) year from the date I sign it. Each year, I will sign a new form to allow FHC staff to continue to talk about my protected health information with other people.

By signing below, I acknowledge that I got a signed copy of this authorization.

_____ _____
Printed Name Date

_____ _____
Signature Relationship

_____
Witness Signature

NOTE: If signed by someone other than the patient, we need written proof of your authority to act on the behalf of the patient.

Family Health Centers

Name _____ DOB _____ Date _____

Pediatric Annual History

Medical History ☐Y No Current Medical Problems

Does your child have or ever had:

EYES, EARS, NOSE, THROAT

1. ☐Y Frequent Sore Throats
2. ☐Y Frequent Colds or Allergies
3. ☐Y Nosebleeds
4. ☐Y Frequent Ear Infections
5. ☐Y Hearing Problems
6. ☐Y Vision Problems
7. ☐Y Speech Problems
8. ☐Y Snoring

HEART, LUNGS

9. ☐Y Heart Murmur
10. ☐Y Heart Defect
11. ☐Y Difficulty Breathing (Dyspnea)
12. ☐Y Shortness of Breath with Exercise
13. ☐Y Cough
14. ☐Y Wheezing
15. ☐Y Asthma
16. ☐Y Positive TB Skin Test
17. ☐Y Sleep Apnea

STOMACH

18. ☐Y Vomiting or Reflux
19. ☐Y Constipation
20. ☐Y Soiling Underwear
21. ☐Y Eating or Digestion Problems
22. ☐Y Abdominal Pain
23. ☐Y Obesity
24. ☐Y Overweight
25. ☐Y Underweight
26. ☐Y Recent Weight Loss _____ lbs.

URINARY

27. ☐Y Pain with Urination
28. ☐Y Urinary Frequency
29. ☐Y Urinating in Underwear
30. ☐Y Bedwetting

GENITAL, FEMALE

31. ☐Y Vaginal Discharge
32. ☐Y Genital Sores (Lesion)
33. ☐Y Genital Warts
34. ☐Y Age at First Period _____ Years Old (Menarche)
35. ☐Y Abnormal Periods (Abnormal Menses)
36. ☐Y Heavy Bleeding During Period

GENITAL, MALE

37. ☐Y Testicular Pain
38. ☐Y Testicular Swelling
39. ☐Y Genital Sores (Lesion)
40. ☐Y Genital Warts
41. ☐Y Penile Discharge

HEAD

42. ☐Y Headache
43. ☐Y Fainting or Passing Out
44. ☐Y Seizures
45. ☐Y Head Injury (Trauma to Head)

MUSCLES AND BONES

46. ☐Y Joint Swelling, Localized
47. ☐Y Joint Pain, Localized
48. ☐Y Fractures
49. ☐Y Muscle or Bone Injury

BLOOD

50. ☐Y Anemia
51. ☐Y Anemia, Takes Iron
52. ☐Y Easy Bleeding
53. ☐Y Easy Bruising Tendency
54. ☐Y Blood Transfusions
55. ☐Y Sickle Cell Anemia
56. ☐Y Sickle Cell Trait

ALLERGY

57. ☐Y Seasonal Allergies
58. ☐Y Prior Allergy Testing or Shots
59. ☐Y Allergy Shots
60. ☐Y Hives (Urticaria)

ALLERGIC REACTIONS TO:

61. ☐Y Insect Bites/Stings
62. ☐Y Foods
63. ☐Y Allergy Free Test

PSYCHIATRIC:

64. ☐Y ADHD
65. ☐Y Depression
66. ☐Y Anxiety
67. ☐Y Bipolar Disorder
68. ☐Y Previous Psychiatric Treatment

PREVIOUS HOSPITALIZATION

69. ☐Y ER Visit
70. ☐Y Hospitalizations
71. ☐Y Psychiatric Treatment

SURGERIES: ☐Y No Surgical History

72. ☐Y Eye Surgery
73. ☐Y Tubes in Ears
74. ☐Y Tonsils and Adenoids
75. ☐Y Heart Defect
76. ☐Y Trauma
77. ☐Y Hernia
78. ☐Y Gallbladder
79. ☐Y Obstruction - Intestine
80. ☐Y Kidney
81. ☐Y Other Surgery

OTHER MEDICAL:

82. ☐Y _____
☐Y _____

Family History

☐Y No Family Medical Problems

Does your child have a parent, brother, sister, or child who has ever had:

1. ☐Y Vision Problems
2. ☐Y Hearing Problems (deafness)
3. ☐Y Birth Defects (heart, spine)
4. ☐Y Heart Disease
5. ☐Y High Cholesterol
6. ☐Y Blood Problems?
7. ☐Y Psychiatric Problems?
8. ☐Y High Blood Pressure
9. ☐Y Sudden Infant Death Syndrome
10. ☐Y Asthma / COPD / Emphysema
11. ☐Y Diabetes
12. ☐Y Thyroid Problems
13. ☐Y Allergies
14. ☐Y Immune System Problems
15. ☐Y Seizures
16. ☐Y Kidney Problems
17. ☐Y Orthopedic (Bone) Problems
18. ☐Y ADHD
19. ☐Y Cancer
20. ☐Y Alcohol Abuse
21. ☐Y Drug Use

Health and Safety

Do you have any of the following:

1. ☐Y Secondhand Tobacco Smoke in Home
2. ☐Y Alcohol Use by Family Member
3. ☐Y Drug Use by Family Member
4. ☐Y Domestic Violence
5. ☐Y Guns in the Home
6. ☐Y Car Seat Used
7. ☐Y Seat Belt Used
8. ☐Y Housing with Smoke Detectors
9. ☐Y Poison Control Phone Number