



Family Health Centers

Care for your Health & Wellness

Fax: 1 (833) 468-4883

www.fhclouisville.org/schools

Iroquois High School Clinic: 502-380-5201

Olmsted South (Telehealth Services): 502-231-8992

Pleasure Ridge Park High School Clinic: 502-742-1253

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.



School Based Clinic Registration Form

School/Teacher: _____

PATIENT INFORMATION (PLEASE PRINT)					
Last Name:	First Name:	Middle:	Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Home Phone Number:	Address:		City:	State:	Zip Code:
PARENT/GUARDIAN					
Guardian #1 Last Name: me: La	Guardian #1 First Name:	Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> Other <input type="checkbox"/> Foster Parent		Guardian lives with student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Cell Phone:	Work Phone:	Email:		Date of Birth:	
Guardian#2 Last Name: me: La	Guardian #2 First Name:	Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> Other <input type="checkbox"/> Foster Parent		Guardian lives with student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Cell Phone:	Work Phone:	Email:		Date of Birth:	
Emergency Contact other than parent:	Emergency Contact Phone Number:	Relationship to Child:		Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Native Hawaiian or Pacific Islander	
How many people live in your home?	(Required) Total Yearly Income:	Language:		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
What is your housing situation today?	<input type="checkbox"/> I have housing <input type="checkbox"/> I choose not to answer this question		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer this question					
Does your child attend Jefferson County Public Schools? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What Pharmacy do you use? _____			Street: _____		
Would you prefer to use the FHC Pharmacy? <input type="checkbox"/> Yes			<input type="checkbox"/> 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:			Date:		
X			X		
Printed Name:					



Tyto Care Telehealth Informed Consent

Patient Information	
Patient Name:	Date of Birth:
Site where patient is seen via Telehealth:	
Consulting Provider Name:	Provider Location:
Introduction	
<p>Your child is going to have a clinical encounter using videoconferencing technology. Your child will be able to see and hear the provider and they will be able to see and hear the child, just as if they were in the same room. Since 1994, technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, and follow-up.</p>	
<p>Expected Benefits:</p> <ul style="list-style-type: none"> Improved access to care by enabling a patient to remain at the school and obtain services from providers at a distant site. Patient remains closer to home where local health care providers can maintain continuity of care. Reduced need to travel for the patient, parent, and the provider. 	
<p>The Process:</p> <p>Your child will be introduced to the provider and anyone else in the room with the provider. Your child may ask questions of the provider or any telemedicine staff in the room with the child, if they are unsure what is happening. If your child is not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.</p>	
<p>Possible Risks:</p> <p>There are potential risks associated with the use of telemedicine which include, but may not be limited to:</p> <ul style="list-style-type: none"> A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision. Technology problems may delay medical evaluation and treatment for today's encounter. In very rare instances, security protocols could fail, causing a breach of privacy of person medical information. 	
Informed Consent	
<p>By signing this form, I understand the following:</p> <ol style="list-style-type: none"> 1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. 2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit. 3. I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured. 4. I agree that I am responsible to Family Health Centers, Inc. for charges resulting from the services rendered using videoconferencing technology at their prevailing rates. 	
<p>Consent to Use Telehealth:</p> <p>I voluntarily give my consent for my child, identified above, to receive telehealth services through Family Health Centers, Inc. I have read and understand the information provided to me above regarding telehealth, and all my questions have been answered to my satisfaction.</p> <p>I understand that this consent will remain valid for the current academic school year unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that Family Health Centers remove my child from services.</p>	



It is my responsibility to notify the school nurse of all updates or changes to my child's health conditions or insurance coverage.

Signature of Patient (or authorized person): _____ Date/Time: _____

If authorized signer, relationship to patient: _____

Verbal Consent:

Parent was contacted by School Based Services staff by telephone. This Telehealth Informed Consent was reviewed with the parent and the parent gave verbal consent for Telehealth Visits.

FHC School Based Services Staff

Date

FHC School Based Services Staff

Date



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.

1	<p>Current Pay Stubs for the most recent one month of work of everyone working in your household.</p> <ul style="list-style-type: none"> • 4 pay stubs if paid weekly, or 2 pay stubs if paid every other week. • This can include unemployment pay-stubs. 	2	<p>Letter from Social Security, SSI, Disability, Unemployment, Food Stamps or other public assistance that shows your income.</p> <p>Only 1 letter is needed.</p>	3	<p>Special Income Form completed by your employer, or an organization or individual that knows your income or situation, like a Church.</p>
				4	<p>Most recent income tax filed or W2 from your employer.</p>

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 Patient Access Specialist know so their sliding-discount can be 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%	126-150%	151-175%	176-200%	More than 200% FPL
\$25/Medical or Behavioral Health visit \$40/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