Updated May 2018

320 Pleasant Hill Road
Gaston, NC 27832
(252) 308-0577
www.rhgnc.org

Dear Parent or Guardian,

Rural Health Group School Based Health Centers provide medical care for students while they are in school. We work with school nurses, teachers, parents and your child's primary doctor to provide medical, behavioral health and resource coordination services. **You do not have to be a Rural Health Group patient in order to receive services through this program.** We offer services to students regardless of insurance status or ability to pay. We do bill private insurance, Medicaid and NC Health Choice for telemedicine services where that is available.

Students must have their parent's written permission to receive services that include treating illness, providing urgent care, helping students manage chronic conditions through our School Based Health Centers and coordinating care if needed with your family physician. Please complete and sign the attached form and return it to the school with your student. If you prefer, you may mail the form to the above address.

We look forward to working with you and your child this year. Parents are encouraged to contact Rural Health Group, Inc. School Based Health Centers with concerns so that we can work together to provide the best care for each student. We are always open to questions/concerns and welcome your feedback.

Please visit our website or call if you need additional information.

Sincerely,

Brittney H Pope

Brittney H. Pope, BSN, RN.
SBHC Director

Maqsood Valliani, MD.
Pediatrician

Kristen Dorsey, MD
Pediatrician

Rural Health Group, Inc. School Based Health Center
Minor Patient Registration Form

By completing this form, I consent in advance to my child having access to any or all available services of Rural Health Group, Inc. School Based Health Centers as long as my child remains enrolled in school. Services include: diagnosis and treatment of common illnesses and injuries, preventive health screenings, health education, mental health services, oral care, and referrals as needed.

Students must have parental permission to be seen at School Based Health Centers.

Student's Name (First, Middle, Last):_____

DOB:_____ Age:_____ Gender:_____ School:_____

Mailing Address:_____ City:_____ Zip:_____

Street Address:_____ City:_____ Zip:_____

Primary Phone:_____ Parent Email:_____

Mother/Guardian:_____ Phone:_____

Father/Guardian:_____Phone:_____

Who does the child live with most of the time?_____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

Primary Care Doctor/Clinic:_____

Pharmacy:_____ Dentist:_____

Person responsible for bill:_____ Relationship:_____ DOB:_____

Is the patient covered by insurance?___ Would you like information about "Sliding Fee"?_____

Primary Insurance/NC Medicaid/NC Health Choice:

Name of Insurance Company:_____ Copay Amount:_____

Ins. ID Number:_____ Group Number:_____

Name of Subscriber:_____ DOB:_____

Patient's Relationship to Subscriber:_____

Secondary Insurance:

Name of Insurance Company:_____ Copay Amount:_____

Ins. ID Number:_____ Group Number:_____

Name of Subscriber:_____ DOB:_____

Patient's Relationship to Subscriber:_____

Rural Health Group, Inc. School Based Health Center Minor Patient Registration Form, *continue*

Child's Name:_____ DOB:_____

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. Rural Health Group, Inc. School Based Health Center staff will share confidential information only in the following situations:

- When it is educationally relevant for a student's academic progress.
- When necessary to address a student's potential health care needs.
- To ensure the safety of the student, other students and school personnel.
- Other situations specified by law.

For example, the School Based Health Center staff may discuss the student's medication and other health care needs with the appropriate staff members who will administer the student's medication and provide care to the student while the student is at school.

Additional detailed information about the Privacy Policies that govern the School Based Health Center is available on our website at www.rhgnc.org.

I, the undersigned,

- Give permission and consent for my child to have treatment through and by the School Based Health Center. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- Give permission for the School Based Health Center to receive information from the school about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website www.rhgnc.org).
- Agree to release all records related to this treatment to the Primary Care Provider.
- Agree that I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
- As Parent/Guardian of the above student, I:
    - Authorize the release of any information necessary to process insurance claims for payment of benefits to Rural Health Group, Inc. School Based Health Centers.
    - Authorize payment of benefits to Rural Health Group, Inc. School Based Health Centers for services rendered.
    - Have provided details of all insurance policies that cover my child.

The information on the preceding page is true and complete to the best of my knowledge.

Parent/Guardian Name (printed):_____

Parent/Guardian Name (signature):_____

Date:_____

Rural Health Group, Inc. School Based Health Center
Health History Questionnaire

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

Is your child allergic to any medications?

_____ Yes, please list:_____

_____ No

Is your child on any medications?

_____ Yes, please list:_____

_____ No

Does your child have any of the following conditions or other health concerns – include details:

___Yes___No**: Allergies**, other than medications (such as bee stings or peanuts)_____

___Yes___No: **Asthma**_____Date of last asthma attack:_____

___Yes___No: **Seizures**_____Date of last seizure:_____

___Yes___No: **Vision Problems**_____

___Yes___No: **Hearing Problems**_____

___Yes___No: **Heart Problems**_____

___Yes___No: **Bleeding Disorders**_____

___Yes___No**: Orthopedic** (bone or joint) **Problems**_____

___Yes___No: **Anxiety/Depression**_____

___Yes___No: **Operations**_____

___Yes___No: **Hospitalizations** (dates and details)_____

___Yes___No: **Chronic Diseases in Siblings**_____

___Yes___No: **Behavioral Issues**_____

___Yes___No**: Frequent absences or disruption from daily activities**_____

___Yes___No: **Other**_____

Additional Details:_____

_____

_____

In signing this form, I am stating the following:

- The information that I have provided is accurate and up-to-date.
- I will update the School Based Health Center with any changes as soon as possible.

If you would like to speak with one of our medical providers to discuss your child's health or concerns, please contact us at (252) 536-5000.

_____ _____

Parent/Guardian Signature Date

Rural Health Group, Inc. Dental Service Request

All dental services will be provided by licensed dentists and hygienists.

1) Is your child currently seeing a dentist? Yes, or No

2) If no, do you consent to the School Based Health Center providing preventive dental services for your child? Yes, or no