PATIENT INFORMATION–SCHOOL

SFSD Only:
Classroom#: _____
IC Medical flag: _____
IC Dental flag: _____

Complete and sign this form if you would like your child to be seen at the School Clinic.

CHILD/PATIENT'S PERSONAL INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Communication Method: ☐ Voice ☐ Text ☐ Both

What is your preferred language: ☐ English ☐ Other _____

Do you need an interpreter ☐ Yes ☐ No

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Chicano ☐ Cuban ☐ Mexican American ☐ Puerto Rican

Race: ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian or Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Choose not to disclose

PARENT/GUARDIAN PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Phone Number: (Primary) _____ (Secondary) _____ Email: _____

SERVICES REQUESTED

Consent for Medical Services (Circle Yes or No):

YES/NO I authorize my child to receive medical services offered by Falls Community Health (FCH) in the school.

IF YES: Notification for Medical Services (CHOOSE ONE and INITIAL ONLY THAT ONE):

_____ I must be notified prior to my child receiving any services. ***—OR—***

_____ I authorize the clinic to provide services to my child if I am unable to be contacted. I understand that these services will include an evaluation by a care provider, and that any recommendations or follow-up will be communicated to me via phone or a visit summary sent to me.

Consent for Dental Services (Circle Yes or No):

YES/NO I authorize my child to receive dental services offered by FCH in the school. I understand that my child will be seen twice per school year in the school dental clinic for a dental examination and a dental cleaning.

If YES: Notification for Dental Services (CHOOSE ONE and INITIAL ONLY THAT ONE):

_____ I must be notified prior to my child being seen for their dental exam and cleaning. ***—OR—***

_____ I authorize my child to receive dental services during the school day. I understand that communication following each visit will be sent home with my child and that any follow-up dental treatment will require a signed treatment plan with my consent in order to be completed in the school-based clinic.

CHILD HEALTH HISTORY

What pharmacy do you use? _____ List any medications: _____

List any allergies: _____

Does your child have any medical or dental concerns? _____

☐ ADHD ☐ Anxiety/depression ☐ Asthma ☐ Diabetes ☐ Epilepsy/seizures ☐ Thumb sucking
☐ Snoring ☐ Speech Problems ☐ Other: _____

Date of last dental exam (MM/YY) _____/_____

INSURANCE

Patient's Medicaid Number: _____

Other Medical Insurance Name: _____ Policy Number: _____

Subscriber First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ____/____/_____ Relationship to Child: _____
MM DD YYYY

Other Dental Insurance Name: _____ Policy Number: _____

Subscriber First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ____/____/_____ Relationship to Child: _____
MM DD YYYY

HOUSEHOLD INCOME-Falls Community Health receives a Federal Grant that allows us to provide discounted fees to patients who qualify based on their household size and income. We are required to collect income information on the patients we serve. We respect that this information is personal and confidential.

If your income is less than the income identified in the table below for your household size, please ask about our sliding fee program.

How many people live in your household? ____ What is your total annual HOUSEHOLD income? $_____

Household Size	Annual Income less than or equal to
1	$31,920
2	$43,280
3	$54,640
4	$66,000
5	$77,360
6	$88,720

What is your current housing situation?

☐ I have a home (own or rent/lease apartment or house)

☐ I do not have a home, I stay at:

☐ Shelter ☐ Street ☐ Doubling Up/Couch-Surfing

☐ Transitional/Halfway House ☐ Other: _____

IMPORTANT—Permission to provide medical and dental treatment

We cannot treat your child if this form is not signed.

By signing below, I as the Parent/Guardian of _____ consent to my child receiving nursing assessments, exams, x-rays, treatments, diagnostic tests, immunizations, health supervision, and medications that any provider at Falls Community Health (FCH) feels is necessary or beneficial to the health of my child. I acknowledge that FCH may use health information exchange to electronically transmit, receive, and/or access my child's prescription history.

I understand this consent at FCH clinics shall be valid until my child enters sixth or ninth grade in the Sioux Falls School District, or until I revoke the consent in writing and deliver the revocation to FCH or the school-based clinic where my child receives care. I authorize FCH to disclose my child's confidential information only for treatment, payments, or health care operations. FCH may share clinical information with the Sioux Falls School District to coordinate care.

I acknowledge that no guarantees have been made to me, and I am aware that I have the right to ask my provider or nurse questions regarding my child's treatment or exam. I have been encouraged to ask and have any questions answered about the risks, benefits, and alternatives of the services by contacting FCH at 605-367-8793 and that FCH recommends that I contact them any time I have questions regarding the services being provided.

I consent to my child receiving healthcare services via telehealth when an in-person clinical provider is not available. I understand that details of my child's medical history, examinations, x-rays, and tests will be discussed with interactive video, audio, and telecommunications technology. Physical examination of my child may take place and nonmedical personnel may be present in the telehealth visit to aid in video transmission. Video, audio, and/or digital photos may be recorded during the telehealth consultation visit.

I authorize Falls Community Health to make audio recordings of my visit(s) with health care providers at the practice. Such recording(s) will be used by the practice for treatment and operations purposes using AI technology. Recordings may be shared with business associates for troubleshooting and product improvement purposes. Recordings will be maintained for a limited period for validation purposes before they are destroyed.

Statement of Financial Responsibility and Assignment of Payer Benefits

I agree that I am financially responsible for all charges related to services provided by Falls Community Health (FCH). I agree FCH will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. My signature on this form is my authorized signature for the filing of a claim and request for direct payment or benefits by any Payer to FCH. I agree that unless FCH has agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts, and charges for noncovered services.

Notice of Privacy Practices and Sharing of Information from School District

I have been offered a copy of this office's Notice of Privacy Practice. A posted copy of the current Notice is in our facility and on our website www.siouxfalls.gov/fch. The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students' personal information held by educational agencies or institutions. I give the Sioux Falls School District permission to share personally identifiable student information with Falls Community Health. This information will only be used to coordinate care with FCH. The information shared will be limited to demographic, insurance status, and health history.

Patient Grievance. Patient inquiry/concern forms are available in waiting rooms or upon request.

Acknowledgement and Authorization

I have read the information above and have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified on the form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient.

_____ _____ _____

Signature of Parent/Legal Guardian | Print Name/Relationship to Patient | Date

Date of Birth: ___/___/____ Social Security Number: _____
MM DD YYYY

FOR OFFICE USE ONLY: Entered into eCW _____ Route to Dental for Appt. _____