

SCHOOL BASED HEALTH CENTER ENROLLMENT PACKET

Must Be Completed Annually

Hello Parents!

Boston Mountain Rural Health Center, Inc. (BMRHC) is excited to announce that they are partnering again with your child's school district to provide the faculty and students high quality, accessible healthcare with the convenience of not having to leave campus! The BMRHC school based health center's (SBHC) focus is to provide primary and preventive medical and behavioral health care to students and faculty that are enrolled in the SBHC. Enrolling is easy and **FREE!**

In order for BMRHC to provide optimal care it is important that we have current information. Please complete the following information and return to your school.

- ☐ School Based Health Center Enrollment Form
- ☐ Patient Demographic Form
- ☐ Consent To Treat
- ☐ HIPAA Privacy Information
- ☐ Statement of Income
- ☐ Health History
- ☐ Immunization Consent Form

Hours of Operation:

SBHC services are available when school is in session during normal work hours. When it is not in session, you may call 870-448-5733 for assistance with your health needs.

Appointments are available:

- Monday - Thursday 7:45am - 5:15pm and Friday 7:45 am - 11:45 am
- BMRHC also offers after hours on-call services for non-emergent needs outside of normal working hours, holidays, and weekends. The number is 870-448-7222 to reach a highly qualified clinical staff member to assist you.

Cost:

- BMRHC accepts all insurances!
- A Sliding Fee Program is available where your child can receive a comprehensive exam for as little as \$10.
- BMRHC also can connect you or your child with someone who can assist you with enrolling in free or low cost health insurance.

¹ Updated: 5/23/24



We suggest that you periodically check our Facebook page or website (www.bmrhc.net) for updates and new information. We look forward to an exciting, healthy year!

SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

School District: _____ Campus: _____

Grade: _____ Graduation Year: _____

Student's Name: First _____ M. _____ Last _____

Student's DOB: _____

*****Please make a selection below:**

- ☐ **YES!** I would like for my child to receive care at the Boston Mountain Rural Health Center School Based Clinic. **If marking yes, Please continue to complete the remainder of this packet.** Services could include treatment for illness or injury, including over the counter medications or necessary prescriptions, well child exams, telehealth appointments, immunizations and emergency services as needed. Please list the best contact number below:
- ☐ **NO!** I do not wish for my child to receive medical care at Boston Mountain Rural Health Center School Based Clinic. **If signing no, you do not have to complete the remainder of this packet. If your child has emergent needs at the school, care will be provided regardless of the selection on the form.**

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ MI: _____ Last Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Social Security #: _____
 Home Phone: _____ Cell Phone: _____
 Parent/Guardian Employer Name: _____ Work Phone: _____
 Emergency Contact Name: _____ Relationship: _____ Ph #: _____
 Primary Care Provider (PCP): _____ PCP Contact Number: _____
 Parent/Guardian Name: _____ Address: _____
 Parent/Guardian Social Security #: _____ Parent/Guardian DOB: _____
 Insurance Name: _____ Member ID #: _____ Group #: _____
 Subscribers Name: _____

Please complete the following section IN REGARDS TO THE PATIENT:

- **Ethnicity (Circle):** Hispanic or Latino, Not Hispanic, Declined to Specify
- **Race (Circle):** Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific Islander, Other Pacific Islander, White, Declined to Specify, More than One Race
- **Primary Language (Circle):** English, Indian, Spanish, Russian, Marshallese, Other
- **Marital Status (Circle):** Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown
- **Veteran (Circle):** Yes/No
- **Education Level (Circle):** Some High School, GED, High School Graduate, Some College, College Graduate
- **Communication Needs (Circle):** None, Visually Impaired, Hearing Impaired, Cognitive Impairment
- **Transportation Barrier (Circle):** Yes, No
- **Sex at Birth:** Male, Female
- **Gender Identity (Circle):** Male, Female, Female to Male/Transgender Male/Trans Man, Male Female/Transgender Female/Trans Woman, Genderqueer, neither exclusively male nor female, Choose not to disclose, Additional Gender Category or other
- **Sexual Orientation (Circle):** Lesbian/Gay/Homosexual, Straight/Heterosexual, Bisexual, Do Not Know, Choose not to disclose, Something Else, please describe _____

*Boston Mountain is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care.

- **Agricultural Worker:** Yes/No (If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)
- **Homeless:** Yes/No (If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)



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• **PREFERRED PHARMACY** _____

I hereby certify that the above information is correct.

Patient Responsible Party Signature

Date

**ADULT & MINOR
CONSENT TO TREATMENT/TELEHEALTH CONSENT**

Patient Name -PRINT

I hereby consent, myself or to whom I am legally responsible to receive outpatient services provided by Boston Mountain Rural Health Center, Inc. ("BMRHC"), including, but not limited to the examination, diagnosis, and treatment. I understand that this consent remains in effect so long as I am a patient of BMRHC, and I understand I may discontinue services at any time.

Our center requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment.

Complete for Minor, if applicable:

If I am unable to be present for my child's visit, the person(s) listed here is/are authorized by me to accompany my child to their visits and sign any necessary consents or acknowledgements on my behalf, including responsibility for payment. **I understand that individuals that accompany my child Must be 18 or Older.**

Name: _____ **Relationship:** _____
Contact #: _____

Name: _____ **Relationship:** _____
Contact #: _____

Complete for School Based Health Centers:

As the parent/guardian, I grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits and as with other health related matters, health information cannot be released without consent. If sports physicals are completed, I give consent to release to my child's school.

Telehealth/Video Conference Services

I have received a copy, read, and understand the telemedicine guidelines. I agree to participate in the telemedicine consult, in which my image and my Protected Health Information (PHI) will be transmitted electronically through the videoconference(s) to health care professionals that are authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services.

I understand that the software system is encrypted, so the likelihood of this transmission being intercepted by unauthorized persons is EXTREMELY small. I understand that I can withdraw my permission at any time prior to the videoconference and/or my interrupt the



videoconference at any time. In either case, I understand that no action will be taken against me, and I may still pursue a consultation in person with a physical or other health care professional. I also understand that if I interrupt the videoconference, the consultation will be incomplete. Therefore, I understand that health care professionals involved in the video conference will be unable to provide treatment or services to me at that time.

I understand that there are limits to Telemedicine Technology. Therefore, there is no guarantee that this Telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

Notification of Privacy

I have received a copy, read, and understand the BMRHC Notice of Privacy Practices. Please be aware that BMRHC's behavioral health services are designed to provide treatment only. Treatment services offered must be medically necessary. Copies of Independent Licensed Practitioner (ILP) and behavioral health service rules are available to patients upon request.

Authorization to Release Information

I hereby authorize BMRHC to release any necessary information acquired in the course of my examination or treatment to any authorized agent related to treatment, payment, or healthcare operations. I further authorize the ability to view prescriptive history from external sources. I further authorize the release of health information to federal and state governing entities for the purposes of required reporting.

Authorization to Pay Benefits

I authorize the clinic to release medical, dental, behavioral health or other such information to the third party insurance carriers for the purposes of filing insurance claims related to my care and understand that I may be billed for services rendered.

Acknowledgement

I acknowledge that I am responsible for the payment of the account balance. I understand that third party service payments may be denied based on the third-party payer's policies and rules. I agree to be responsible for all amounts not covered by my insurance.

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

Patient Signature or Designated Representative (If minor, Parent or Legal Guardian)

Date



HIPAA PRIVACY

HIPAA/Protected Health Information (PHI) Disclosure

Patient Name -PRINT

Boston Mountain Rural Health Center, Inc. (BMRHC) is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization. Please understand that this may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

BMRHC participates in programs, such as the State Health Alliance for Records Exchange (SHARE), CommonWell and CareQuality to share and receive your health information statewide among your doctors, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs. If you wish to opt-out, you must ask your health care provider for and complete an Opt-Out Form. You can also opt-out for your minor child (under the age of 18) using the same process.

In an effort to serve you more efficiently, BMRHC opts patients into an automated system to remind you of appointments, lab notices by portal, health maintenance reminders, prescription confirmation and general notifications. You will be contacted using the latest contact information on file. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. You may opt out at any time.

BMRHC offers access to medical information through the patient portal and/or Healow application. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. I understand that it is my responsibility to let BMRHC know when my email address has changed.

[] I wish to Web Enable my account (Patient Portal) **ONLY FOR PATIENTS 18 YEARS AND OLDER**

Email: _____

BMRHC also realizes you may have family members or significant people whom you may wish your provider speak with regarding your healthcare information. Please specify the individual(s) and their relationship to you so that your healthcare team has permission to discuss your Protected Health Information (PHI) healthcare information. It is your responsibility to communicate any changes to BMRHC staff and request an update in your medical record.

Individual's Name

Phone Number

Relationship to You

_____	_____	_____
_____	_____	_____
_____	_____	_____



By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

Patient Signature Or Designated Representative

Date

Statement of Income

As a Federally Qualified Health Center, Boston Mountain is required to collect income information on all patients even if you choose not to participate in the Sliding Fee Scale Program. Please choose your household gross annual income range:

☐ \$0 - \$11,880	☐ \$11,881 - \$23,881	☐ \$23,882 - \$34,882
☐ \$34,883 - \$45,883	☐ \$45,884 - \$56,884	☐ \$56,885 - \$67,885
☐ \$67,886 - \$77,886	☐ \$77,887 - \$88,887	☐ \$88,888 - \$99,888
☐ \$99,889 - \$110,889	☐ \$110,890 - Above	☐ Choose not to disclose

****Please ask the receptionist for more information on the Sliding Fee Scale Program***

Number of Household Members (Including Self): _____

Patient OR Parent/Guardian Signature

Date

STUDENT HEALTH HISTORY

Child's Name: _____ DOB: _____

Are there any problems that concern you about your child?

Does your child have any **allergies** (food, medication, environmental)? Please list the allergy and the reaction:

Current medications (include vitamins/fluoride/supplements):

1. _____ Prescribed by: _____
2. _____ Prescribed by: _____
3. _____ Prescribed by: _____

Date of last physical examination: _____ By Whom: _____

Date of last dental examination: _____ By Whom: _____

Date of last eye examination: _____ By Whom: _____

List hospitalizations, illnesses, accidents, broken bones, surgeries, etc. Please include Date and Child's age and explain: _____

Please list any specialist that your child currently sees:

1. _____ Location: _____
2. _____ Location: _____
3. _____ Location: _____



Health History Continued:

Personal History (Patient)

Name: _____ Date: _____
Date of Birth ____/____/____ (mm/dd/yyyy)
Age _____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							



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Other							
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**Boston Mountain Rural Health Center School Based Health Center
Immunization Consent Form**

Vaccines/Immunizations are offered at our BMRHC School Based Health Centers to protect your student against serious diseases. Vaccines are designed to prevent life threatening, debilitating illnesses and cancer. Before vaccinating, BMRHC checks the WebIZ database records to confirm that students are only given vaccines they have not received and parents will be called prior to vaccine given to notify and answer any questions you may have.

COMPLETE ALL SECTIONS AND SIGN IF YOU ARE AUTHORIZING YOUR CHILD TO HAVE VACCINES ADMINISTERED BY BMRHC AS MARKED IN THIS DOCUMENT BY YOU AS PARENT/LEGAL GAURDIAN.

A. Information about Student

School Name: _____
 Student First Name: _____ Student Middle Initial: _____
 Student Last Name: _____ Student Birthdate: _____
 Student Age: _____ Student Gender: _____
 Parent / Guardian First Name: _____
 Parent / Guardian Last Name: _____ Relationship to Student: _____
 Student's Address: _____ City: _____ Zip Code: _____

B. Vaccine Eligibility Screening

Medicaid: My child/teen has Medicaid.
ARKids: My child / teen is on ARkids.
Private Insurance: My child/teen is covered by private/commercial insurance plan, which includes vaccines with no cap on how much they cover (*Private Insurance will be referred to Health Department for Vaccines*)
Vaccine Coverage: My private/commercial plan does not cover vaccines or caps how much they cover for vaccines.
Not Insured: May child/teen does not have health insurance

C. Vaccine Health Screenings (Mark "YES" OR "NO" or "Don't Know")

1. How you child/teen had a serious reaction to a vaccine in the past?	Yes	No	Don't' Know
2. Has your teen had a brain or other nervous system problem?	Yes	No	Don't Know
3. Has the child, a sibling, or a parent had a seizure?	Yes	No	Don't Know
4. Is your child/teen pregnant?	Yes	No	Don't Know
5. Has your child/teen ever felt dizzy or faint before, during, or after a shot?	Yes	No	Don't Know
6. Does your child have allergies to medicine, food, any vaccine component for the listed vaccines (below), or latex?	Yes	No	Don't Know
7. Does the child/teen have an immune-system problem such as cancer, Leukemia, HIV/AIDs?	Yes	No	Don't' Know
8. Does the child/teen's parent or sibling have an immune system problem?	Yes	No	Don't Know
9. In the past year has the child/teen received immune (gamma) globulin, blood/blood products, or an antiviral drug?	Yes	No	Don't Know

If you answer "Yes" to any of these, it *does not necessarily* mean your child/teen should not be vaccinated, it just means additional questions must be asked.

Note: Additionally, the day of the visit for a vaccine(s), the following questions will be asked.

- 1.) Is the child to be vaccinated sick today?
- 2.) Is the child/teen to receive a vaccine(s) anxious about getting a shot today?

D. Vaccine/Immunizations Content

Each of the vaccines listed below are recommended by the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practice. The Center for Disease Control (CDC) maintains a current list of vaccine Information Statements (VIS) for each vaccine. For the most **current VIS**, please visit <https://www.cdc.gov/vaccines/hcp/vis/current-vis.html> to find the Vaccine Information Statements, please review prior to consenting.

I authorize my student (named on this form) to receive the recommended vaccines and booster doses (MARKED IN THE LIST BELOW) per the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunizations Practice at the School Based Health Center or other BMRHC service location. I also attest that I have read the most current Vaccine Information Statements (VIS) provided at the CDC link shared above by BMRHC and are aware of the risks and benefits of the recommended vaccines listed below. I understand that I will be notified by phone prior to vaccine administration and provided the opportunity to voice any questions or concerns prior to administration of the vaccine.

Parent Name – Please Print: _____

Authorization (Parent/Guardian Signature): _____

Phone #'s where parent(s) can be reached prior to vaccination: _____

Immunizations List

The BMRHC/SBHC staff will review your child/teen's vaccine record (via WebIZ – state immunization registry) to determine which shots are needed according to the CDC recommended vaccine schedule.

Select **ALL** vaccines you **DO authorize administered** to your student named above, by the School Based Health Center or other BMRHC service location. **Mark an X in the box in the left column for each vaccine you authorize.**

School Required Immunizations	
Vaccine Name	Disease
☐ DTaP	Diphtheria, Tetanus, Acellular Pertussis
☐ Tdap	Tetanus, Diphtheria, Acellular Pertussis
☐ IPV	Polio
☐ MMR	Measles, Mumps, Rubella
☐ MCV4	Meningococcal Meningitis (Men A)
☐ Hep B	Hepatitis B
☐ Varicella	Chicken Pox
Required For Children under 5	
☐ Rotavirus	Severe Diarrhea
☐ Hib	Bacterial Disease
☐ PCV13	Pneumonia
Pediatric/Adolescent Recommended Immunizations	
☐ HPV	Human Papillomavirus
☐ Hep A	Hepatitis B
☐ Men B	Meningococcal B
☐ Influenza	Flu
☐ COVID-19	COVID-19