Behavioral Health Enrollment Form

Questions or concerns? Call (475) 231-6978

SBHC School-Based Health Care

Community Health Center, Inc.

I give my child/self permission to obtain SCHOOL-BASED BEHAVIORAL HEALTH/COUNSELING SERVICES while enrolled in a school serviced by Community Health Center, Inc. (CHC) or until I revoke permission. ❑ YES ❑ NO

All insurances will be billed at time of visit.

I certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the student/patient's health. I will notify CHC of any changes to medical information. ❑ YES ❑ NO

I have reviewed CHC's Rights and Responsibilities Policy at sbhc1.com. ❑ YES ❑ NO

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION:

I authorize the release of any medical, dental or behavioral health information necessary to process my claim. I also authorize payment of health benefits to Community Health Center, Inc. for services provided.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I understand that information regarding how CHC will use and disclose my information can be found in CHC's Notice of Privacy Practices and I have received a copy. In addition to the uses and disclosures detailed in the Notice of Privacy Practices, I agree to permit CHC to send text messages to my child (only for scheduling purposes) or to me if a cell phone number(s) is listed below.

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION:

I hereby authorize CHC to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable, and/or to exchange physical exam and immunization information required by law. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights & Privacy Act.

How did you hear about our services? ❑ Internet ❑ Friend ❑ School ❑ Newsletter ❑ Other: _____

PATIENT INFORMATION

*** Required information.**

Full Legal Name (First/Middle/Last): _____

Address/Apt #: _____

City/State/ZIP: _____

Social Security Number: _____ DOB (MM/DD/YY): _____

Primary Language: _____ Sex: ❑ Male ❑ Female ❑ Undefined

Gender: ❑ None ❑ Identifies as Male ❑ Identifies as Female ❑ Female-to-Male ❑ Male-to-Female ❑ Neither exclusively Male nor Female, Genderqueer ❑ Other (Specify): _____ ❑ Choose not to disclose

School Patient Attends: _____ Grade: _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Race:

- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ White
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Patient Declined
- ❑ State Prohibited
- ❑ Unspecified

Primary Care Provider's Name: _____

Phone Number: _____

Dentist's Name: _____

Phone Number: _____

For assistance applying for Medicaid/Husky or other insurance options, TEXT "help" to (860) 560-1398 and an Access to Care team member will contact you.

INSURANCE INFORMATION

*** Medical Insurance:** _____ *** Medicaid ID #:** _____ *** Private Ins. ID/Policy #:** _____ *** Group Number:** _____

*** Insurance Address:** _____ *** Insurance Phone Number:** _____ (info on back of card)

*** Policy Holder Name:** _____ *** Policy Holder DOB** (MM/DD/YY)**:** _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Patient: _____ DOB (MM/DD/YY): _____

*** Address/Apt #** (If different from above): _____ City: _____ ZIP: _____

I agree that messages can be left for me on: ❑ Home Phone ❑ Cell Phone ❑ Work Phone

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Student's Cell Phone: _____ Student's Email Address: _____ Email Address of Parent/Guardian: _____

EMERGENCY CONTACT (If different than Parent/Guardian)

Name: _____ Relationship to Patient: _____ Phone Number: _____

*** Signature of Parent/Legal Guardian or Student if over 18 years old:** _____

If not patient or parent, proof of legal authority must be provided.

*** Print Name:** _____ **Date:** _____

By signing above, I understand and acknowledge that I have read and understand this consent and I have received CHC's Notice of Privacy Practices currently in effect.

Student/Patient Behavioral Health History

Patient Name: _____ Date of Birth (MM/DD/YY): _____

Please contact CHC with any changes to this behavioral health history.

Has the patient ever had counseling services? ❑ YES ❑ NO
If yes, when and with whom?

Has the patient ever had any of the following:

Family changes	❑ YES ❑ NO	Anger issues	❑ YES ❑ NO
School issues	❑ YES ❑ NO	Attention difficulties	❑ YES ❑ NO
Social/peer stresses	❑ YES ❑ NO	Sadness and/or mood swings	❑ YES ❑ NO
Anxiety	❑ YES ❑ NO	Truancy/school avoidance	❑ YES ❑ NO
Learning disabilities	❑ YES ❑ NO	Recent loss	❑ YES ❑ NO

Please explain any other behavioral health concerns your child may have: