School Based Health Centers

What is the School Based Health Center (SBHC) located at Pulaski Schools?

The SBHC is a **full service health center** operated by ConnextCare and partially funded by the State of New York. The SBHC will provide **prompt, quality** and **convenient** primary health care to enrolled students, staffed by a Nurse Practitioner or a Physician Assistant. A physician will always be available for consultation if illness or injury warrants.

Primary Care is available to students who enroll in the SBHC program. The provider will provide treatment of illnesses. If a prescription is necessary, the provider will send it to the pharmacy of your choice. Providers will also treat minor injuries, monitor and treat chronic illnesses such as asthma, hay fever and give immunizations. They also will give comprehensive physical examinations in accordance with the American Academy of Pediatrics guidelines.

Behavioral Health services to students and their families. These services include:

Individual counseling
Group counseling
Psychoeducational and behavioral case reviews
Substance abuse counseling
Family counseling

What is the cost to me? There is no cost to you for the visits at the SBHC. We bill most insurances and we accept as payment what these companies have paid. You are not responsible for co-pays, deductibles, or balances of visits; there is no expense to you. You may receive an explanation of benefits (EOB) from your insurance but you will not receive a bill from the SBHC.

What costs am I responsible for? Services provided at the SBHC are at no cost to you, however you will be charged for:

Prescriptions
Lab work
X-rays
Specialty appointments

What happens if my child is home sick and school is open? You may walk in or call to schedule an appointment at the SBHC.

What happens if my child is sick and school is closed? The SBHC is open when school is open. When school is closed the SBHC is closed. The primary care sites in the ConnextCare Network serve as the back-up facilities. However, if a student is seen at

one of the primary sites in the ConnextCare Network standard charges will apply.

How does my child receive services? Call and schedule an appointment, or send a note into school with your child requesting an appointment with a number where you can be reached. If your child becomes sick or injured at school they can go to the nurses office, the nurse can evaluate the sickness or injury. If she suggests further attention, you will be notified and an appointment scheduled.

How do I sign my child/children up? All school-aged children who are enrolled in and attending public school in the Pulaski School District are eligible to participate, and you may enroll your child at any time during the school year. You will need to complete an enrollment form for each child. You may get these enrollment forms at school nurse's office or at the SBHC located in your school. If you need assistance we would be happy to help you.

Deciding to enroll in the School-Based Health Center is not required for new student enrollment into the Pulaski School District. You may enroll your child/children at the Health Center at any time during the school year if you are interested in this service.

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SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

What services would you like to enroll your student in? ☐ **Medical** ☐ **Dental** ☐ **Counseling**

STUDENT INFORMATION			
Name (First, MI, Last)		Date of Birth	Gender at Birth ☐ Male ☐ Female
Street Address/PO Box	City	State	Zip
School Name	Grade	SS#	Mother's Maiden Name

As a federally qualified health center, ConnextCare MUST ask you to complete the following questions:

Gender Identity: ☐ Choose not to disclose

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ More than one race ☐ Unknown ☐ Other ☐ Choose not to disclose

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Choose not to disclose

Primary language spoken at home:

Household size & income:

Number of people in household: _____ Household income per year $ _____ ☐ Choose not to disclose

PARENT/LEGAL GUARDIAN INFORMATION: ******Person(s) who has the legal rights to make medical decisions for student******

Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian ☐ Other: _____ *Please provide copy of court orders regarding custody/guardianship, if applicable*	Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian ☐ Other: _____ *Please provide copy of court orders regarding custody/guardianship, if applicable*
Mailing address if other than student's address:	Mailing address if other than student's address:
Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Ok to leave Message/Text : ☐ Yes ☐ No	Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Ok to leave Message/Text : ☐ Yes ☐ No

Who Does Student Live With? (Check all that apply) ☐ Father ☐ Mother ☐ Grandparent(s) ☐ Guardian ☐ Step-Parent ☐ Other:

Additional Emergency Contact Name: Phone:

Primary Medical Insurance	**Dental Insurance**
☐ The Student ***HAS*** Medical Insurance ☐ The Student ***DOES NOT*** have Medical Insurance ☐ I am interested in receiving insurance options	☐ The Student ***HAS*** Dental Insurance ☐ The Student ***DOES NOT*** have Dental Insurance ☐ I am interested in receiving insurance options
Insurance Company Name:	Insurance company Name:
Medical Policy #:	Dental Policy #:
Employer:	Employer:
Billing Address of Insurance Co:	Billing Address of Insurance Co:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's SS#"	Policy Holders SS#:
I have additional Medical Insurance (name of insurance co.)	I have additional Medical Insurance (name of insurance co.)

I understand that it is my responsibility to notify ConnextCare of any changes to the information provided on this form and, when applicable, to provide the office with the most up-to-date custody/guardianship paperwork for my child.

_____ Name of Person completing this form

_____ Signature

_____ Date

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ConnextCare Policies and Consents for School Based Health Center Medical Services

Student Name: _____ Date of Birth: _____

CONSENT FOR MEDICAL SERVICES:

☐ I authorize my child to receive medical services provided by the staff of the ConnextCare School Based Health Center Program. Services may include, but are not limited to the following:

- Comprehensive physical examinations (Well Child, Sports, Working Paper etc.)
- Treatment of illness and injury
- Management of chronic medical conditions
- Primary and preventative health care
- Referral to outside agencies (specialists, counselors, etc.) for services not provided at the School Based Health Center

The ConnextCare School Based Health Care believes that parental involvement is essential in keeping children healthy and encourage each student to involve his or her parents in healthcare decisions. We encourage parents/guardians to visit or call the school based health center at any time. Per federal and state law, adolescent patients have the right to consent to reproductive and certain confidential services independently. Parents/Guardians may not have access to this information unless the patient consents.

☐ I consent to the sharing of information between the School Based Health Center and essential school personnel (school nurse, counselor, special education, speech therapist etc.) for treatment/medical purposes.

☐ I consent to photographs, video, digital or other images required to document care in the confidential medical record.

PERMISSION TO DISCLOSE TO FAMILY OR OTHER INDIVIDUALS:

Pediatric Consent

Non-parental consent: For pediatric patients under the age of 18, you may designate another person to attend visits and authorize treatment decisions.

☐ No, I do not give consent to others, only the patients parents/legal guardians will consent to treatment.

☐ Yes, I give consent for the following individual(s) (ie: step-parent, grandparent, friend) to attend appointments, give consent for services, and to make treatment decisions for my child in my absence. This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s)	Relationship to Student	Phone Number

FINANCE POLICY:

ConnextCare's School Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have **NO out-of-pocket costs**. However, if the student requires services that are not provided at the SBHC (x-rays, labs etc.), there may be out of pocket costs incurred.

☐ I authorize ConnextCare and its representatives to release any information they obtain, including medical information, to the insurance company to process claims for payment. In addition, I authorize the insurance company to pay ConnextCare for services rendered.

NOTICE OF PRIVACY PRACTICES/PATIENT BILL OF RIGHTS:

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices, Non-Discrimination Notice, and Patient Bill of rights before signing this Consent Form or at any time by request. The most current Notice of Privacy Practices, Non-Discrimination Notice, and Patient Bill of Rights can be found on our Website at www.connextcare.org.

☐ I acknowledge that I have received/been made aware of our **Notice of Privacy Practices** and our **Patient Bill of Rights**.

☐ I would like the School Based Health Center to act as my child's Primary Care Provider.

☐ My child has a Primary Care Provider that they will continue to see. Name, City:

_____ _____ _____

Name of Person completing this form | Signature | Date

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ConnextCare Medical History Form

Student Name: _____ Date of Birth: _____

PREFERRED PHARMACY/HOSPITAL INFORMATION:

Name/Location of Pharmacy _____ **Telephone #** _____

In the case of an Emergency, which Hospital would you prefer your child be transported to? _____

PATIENT BIRTH HISTORY:

Birth Weight _____ Length _____ Place of Birth _____

☐ Yes ☐ No Any medical problems at birth? If yes, please list _____

PATIENT MEDICAL HISTORY:

Date of Last Physical Exam: _____

☐ Yes ☐ No Does your child have any medication allergies? _____

☐ Yes ☐ No Does your child have any environmental allergies? If yes, please list allergies: _____

Is your child taking any medications? ☐ Yes ☐ No If yes please list _____

_____

Has your child had any of the following?

☐ Diabetes	☐ Bleeding Problems	☐ Colds (6 or more per year)	☐ Convulsions or Fainting
☐ Eye Problems	☐ Kidney Problems	☐ Sleeping Problems	☐ Heart Problems
☐ Asthma	☐ Chicken Pox	☐ Mumps	☐ 3 Day Measles
☐ Nerve Problems	☐ Urinating Problems	☐ Ear Infections	☐ 10 Day Measles
☐ Broken Bones	☐ Dental Problems	☐ Whooping Cough	☐ Pneumonia

☐ Yes ☐ No Serious Accidents _____

☐ Yes ☐ No Operations/Surgery _____

☐ Yes ☐ No Hospital Visits – Overnight _____

☐ Yes ☐ No Any other concerns about your child that you would like us to be aware of? _____

FAMILY HISTORY:

Have any family members had any of the following?

☐ Diabetes	☐ Bleeding Disorder	☐ Cancer	☐ Kidney Problems	☐ Recent Contagious Disease
☐ Heart Disease	☐ Low Blood Pressure	☐ Anemia	☐ High Blood Pressure	☐ Drinking Problem/Alcoholism
☐ Asthma	☐ Sickle Cell Anemia	☐ Tuberculosis	☐ Developmental Disabled	☐ Nervous Breakdown
☐ Drug Problems	☐ Rheumatic Fever	☐ Behavioral Health Issues		

Other, please explain _____

BEHAVIOR AND SCHOOL:

☐ Yes ☐ No Does your child get along well in school? _____

Does your child suffer from any of the following?

☐ Fussiness	☐ Won't Mind	☐ Thumb Sucking	☐ Can't Toilet Train	☐ Eats Dirt, Paint, or Glue
☐ Nail Biting	☐ Bed Wetting	☐ Overactive	☐ Slow Learner	☐ Bad Temper
☐ Jealousy	☐ Holds Breath	☐ Miserable/ Withdrawn	☐ Doesn't Pay Attention	☐ Speech Problems

Other, please explain _____

_____ _____ _____

Name of Person completing this form | Signature | Date

ConnextCare

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

ConnextCare
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61 Delano Street, Pulaski, New York, 13142-1303
Phone: (315) 298-6500 Fax: (315) 298-7468 TDD: 711
www.connextcare.org

Pulaski Location
61 Delano Street
Pulaski, New York 13142
Phone: 315- 298-6564 Fax: 315- 298-3968

THIS SECTION IS FOR OFFICE USE ONLY
Date Received _____
Date Completed _____
By _____

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name (Include any Maiden names &/or Alias)	Date of Birth	Medical Record Number
Patient Address	SS#	Phone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS related information only if I place my initials on the appropriate line in item 9. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug, Substance Use Disorder treatment (SUD), or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS/SUD/MH related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signed this form.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in Item 2), and this re-disclosure may no longer be protected by federal or state law. I understand that in compliance with New York State statute, I shall pay a fee of $.75 per page or $3.00 (whichever is less). There is no charge for referral care of follow up treatment.

6. Name, Phone Number, Fax Number, and Address of Provider or Entity to Release this Information:

7. Name, Phone Number, Fax Number, and Address of Person(s) to Whom this Information Will Be Disclosed:
ConnextCare SBHC at Lura Sharp Elementary School - Phone: 315-298-2570; Fax 315-298-7457

8. Reason for Release of Information:
☐ Changing Primary Care Physician ☐ Specialist/Referral/Continuity of Care ☐ Legal or Insurance purposes ☐ Other: _____

9. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)
☐ All health information (written and oral), except: _____
☐ Only the following specific information: _____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS related Information		

10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
WITNESS SIGNATURE DATE

This form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.