Community Health Center, Inc. is at your school!

In-School Services Provided

Telecare available for some services

Behavioral Health:

- Crisis Intervention
- Individual Counseling
- Group Counseling
- Family Counseling
- Referrals

Community Health Center, Inc.

SBHC

School-Based Health Care

Please keep this sheet for your records.

***Questions or concerns?* Call 860-852-0871 or 203-639-3765**

Leave a message and a School-Based Health Care staff member will return your call.

You can also enroll online at **www.sbhc1.com** or email us at **SBHCinfo@chc1.com**.

Behavioral Health Enrollment Form

SBHC School-Based Health Care

860-852-0871 or 203-639-3765

Community Health Center, Inc.

I give my child/self permission to obtain BEHAVIORAL HEALTH/COUNSELING SERVICES while enrolled in a school serviced by CHC or until I revoke permission. ❑ YES ❑ NO

- All insurances will be billed at time of visit. No out of pocket fees or copays associated with services rendered in school.

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 received a copy of CHC's Rights and Responsibilities Policy. ❑ YES ❑ NO

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION: ❑ YES ❑ NO

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: ❑ YES ❑ NO

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: ❑ YES ❑ NO

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.

PATIENT INFORMATION

*** Required information.**

Full Legal Name: _____ (First / Middle / Last) Date of Birth: _____

Street Address/Apt #: _____ City: _____ ZIP: _____

Sex: ❑ Male ❑ Female Social Security Number: _____ Ethnicity (check box): ❑ Hispanic ❑ Non-Hispanic

Race (check box): ❑ Unknown ❑ American Indian ❑ Pacific Island ❑ Alaskan Native ❑ Black ❑ Asian ❑ White ❑ Other _____

Patient's Primary Language: _____ Does the patient qualify for free/reduced lunch?: ❑ Yes ❑ No

School Patient Attends: _____ Grade: _____

Primary Care Provider's Name: _____ Phone Number: _____

Dentist's Name: _____ Phone Number: _____

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:** _____

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

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

*** Policy Holder Name:** _____ *** Policy Holder DOB:** _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Patient: _____ DOB: _____

*** Street 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:** _____

*** 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 Medical History

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Does the patient have any medical conditions?	❑ YES	❑ NO	Explain:
Does the patient take any medications? (including inhalers)	❑ YES	❑ NO	List all medications:
Has the patient had any serious injuries?	❑ YES	❑ NO	Explain:
Does the patient have a birth or heart defect or have history of a heart problem or surgery?	❑ YES	❑ NO	Explain:
Has the patient ever been hospitalized overnight?	❑ YES	❑ NO	Explain:
Has the patient had any surgery in the past?	❑ YES	❑ NO	Explain:
Has the patient had any shunts placed or has an indwelling catheter?	❑ YES	❑ NO	Explain:
Is/was the patient a teen parent?	❑ YES	❑ NO	
Is the patient pregnant or possibly pregnant?	❑ YES	❑ NO	Due date:
Is the patient currently nursing?	❑ YES	❑ NO	
Is premedication with antibiotics needed prior to dental procedures?	❑ YES	❑ NO	Explain:
Does the patient smoke or chew tobacco?	❑ YES	❑ NO	

Does the patient have or had any of these PROBLEMS?

Anemia/blood disorders	❑ YES	❑ NO	Pneumonia	❑ YES	❑ NO
Asthma	❑ YES	❑ NO	Rheumatic fever, heart disease, murmur	❑ YES	❑ NO
Autism	❑ YES	❑ NO	Scoliosis	❑ YES	❑ NO
Bladder or kidney infections	❑ YES	❑ NO	Seizures	❑ YES	❑ NO
Cancer/leukemia	❑ YES	❑ NO	Thyroid disease	❑ YES	❑ NO
Chicken pox	❑ YES	❑ NO	Tuberculosis	❑ YES	❑ NO
Diabetes	❑ YES	❑ NO	Ulcer/digestive problem	❑ YES	❑ NO
Eating issues	❑ YES	❑ NO	Any mental health issues?	❑ YES	❑ NO
Endocrine/gland disease/ autoimmune disease	❑ YES	❑ NO	Any birth or congenital defects (spina bifida, brain, heart, lung, etc.)?	❑ YES	❑ NO
Headaches/migraines	❑ YES	❑ NO	Any problems with teeth?	❑ YES	❑ NO
Hepatitis or liver problems	❑ YES	❑ NO	Any teeth causing pain?	❑ YES	❑ NO
Learning/developmental issues	❑ YES	❑ NO	Any bleeding when brushing or flossing?	❑ YES	❑ NO
Mononucleosis	❑ YES	❑ NO	Had a dental cleaning within the last 6 months?	❑ YES	❑ NO
Overweight/obesity	❑ YES	❑ NO	Other:	❑ YES	❑ NO

ALLERGIES

Any foods (including lactose intolerance)	❑ YES	❑ NO	Comment:
Any medications (including over the counter or antibiotics; penicillin or amoxicillin)	❑ YES	❑ NO	Comment:
Local anesthetics (including lidocaine) or latex	❑ YES	❑ NO	Comment:
Does the patient have an Epi-Pen at school?	❑ YES	❑ NO	Comment:
Other:			Comment:

BEHAVIORAL HEALTH Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services? ❑ YES ❑ NO

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

If answered yes to any of the above, please comment:

Community Health Center, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Community Health Center, Inc. (CHCI) respects the privacy and confidentiality of your health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your health information and how you can get access to this information. This Notice applies to uses and disclosures we may make of all your health information whether created or received by us.

I. Our Responsibilities to You

We are required by law to:

1. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.
2. Comply with the terms of our current Notice.

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. Should we make material changes, revised notices will be made by posting in the various CHCI offices and will be available on CHCI's website. Copies of the revised notice will also be available at the front desk of the office in which you receive care or by mail from the Privacy Officer of Community Health Center, Inc., 575 Main Street, 2nd Floor, Middletown, Connecticut, 06457.

II. How the Community Health Center, Inc. May Use or Disclose Your Health Information

A. For Treatment, Payment and Healthcare Operations

1. ***For Treatment.*** CHCI may use and disclose your health information to provide you with treatment and services and to coordinate your continuing care. Your health information may be used by doctors, counselors, dentists, and nurses, as well as by lab technicians, dieticians, specialists or others involved in your care, both within and outside CHCI. For example, a pharmacist will need certain information to fill a prescription ordered by your doctor.
2. ***For Payment.*** CHCI may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.
3. ***For Health Care Operations.*** CHCI may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:
   - Evaluate the performance of our staff;
   - Assess the quality of care and outcomes in your case and similar cases;
   - Learn how to improve our facilities and services; and
   - Determine how to continually improve the quality and effectiveness of the health care we provide.

B. Other Uses and Disclosures We May Make Without Your Written Authorization

1. ***Health Care Messages.*** CHCI may use your information to call, email (if you provided an email address), text (if you provided a cell phone number), mail letters or postcards, or send to your patient portal to provide you with appointment reminders, flu shot reminders or other messages about your health care. You may request that CHCI not use one or more of those methods for providing reminders or other health care messages.
2. ***Required by Law.*** CHCI may use and disclose information about you as required by law.
3. ***Persons Involved in Your Care or Payment for Your Care.*** We may disclose health information about you to a family member, close personal friend or other person you have told us that we can share information with about you. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care and will only be made to those individuals you have told us that we may communicate with about you.
4. ***Public Health Activities.*** We may disclose your health information for public health activities. These activities may include, for example: 1) to prevent and control disease, injury or disability; 2) to report problems with medications; and 3) to report immunizations to the CIRTS registry.
5. ***Reporting Victims of Abuse, Neglect or Domestic Violence.*** If we believe that you have been a victim of abuse or neglect, we may disclose your health information to notify a government authority.

6. ***Health Oversight Activities.*** We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include, for example, audits, investigations, inspections and licensure actions.

7. ***Judicial and Administrative Proceedings.*** We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process.

8. ***Law Enforcement.*** We may disclose your health information for certain law enforcement purposes, including, for example, to file reports required by law or to report emergencies or suspicious deaths; to comply with a court order, warrant, or other legal process; to identify or locate a suspect or missing person; or to answer certain requests for information concerning crimes.

9. ***Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.*** We may release your health information to a coroner, medical examiner, funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.

10. ***To Avert a Serious Threat to Health or Safety.*** When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

11. ***Military and Veterans.*** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities.

12. ***National Security and Intelligence Activities; Protective Services for the President and Others.*** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

13. ***Inmates/Law Enforcement Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.

14. ***Workers' Compensation.*** We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

15. ***Disaster Relief.*** We may disclose health information about you to an organization assisting in a disaster relief effort.

16. ***Treatment Alternatives and Health-Related Benefits and Services.*** We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

17. ***Business Associates.*** We may disclose your health information to our business associates under a Business Associate Agreement.

18. ***Research.*** CHCI may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal, established protocols, and has approved the research to ensure the privacy of your health information.

19. ***Health Information Exchange.*** CHCI utilizes an electronic health exchange that allows it to share clinical information with other doctors, nurses, hospitals, and healthcare facilities. The program assists in providing the best possible care by allowing providers outside of CHCI to see your clinical information. This includes your current and past medical, behavioral health, and dental records at CHCI. Healthcare providers and authorized personnel that participate in the electronic health exchange will be able to access your health information more effectively and accurately. If you do not wish to be enrolled in the electronic health exchange, please request an opt-out form.

C. Your Written Authorization is Required for All Other Uses or Disclosures of Your Health Information

1. We will obtain your written authorization (an "Authorization") prior to making any use or disclosure other than those described above. Most uses and disclosures of psychotherapy notes (as defined in 45 CFR §164.501), uses and disclosures of your protected health information that are made for marketing purposes or disclosures that constitute a sale of protected health information require your written authorization.

2. A written Authorization is designed to inform you of a specific use or disclosure (other than those described above) that we plan to make of your health information. The Authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written Authorization will also specify the name of the person to whom we are disclosing the information. The Authorization will also contain an expiration date or event.

3. You may revoke a written Authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for those purposes specified in the Authorization except where we have already taken action in reliance on your Authorization.

D. Your Rights Regarding Your Health Information

1. ***Right to Request Restrictions.*** You have the right to request that we restrict the way we use or disclose your health information for treatment, payment or health care operations. However, we are not required to agree to the restriction except under limited circumstances. For example, we must agree to your request to restrict disclosures about you to your health plan for purposes of payment or healthcare operations that are not required by law if the information pertains solely to a health care item or service for

which you have paid us in full out of pocket. If we do agree to a restriction, we will honor that restriction except in the event of an emergency.

2. ***Right to Request Confidential Communications.*** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable request.

3. ***Right of Access to Personal Health Information.*** You have the right to inspect and, upon written request, obtain a copy of your health information.

4. ***Right to Request Amendment.*** You have the right to request that we amend your health information. Your request must be made in writing and must state the reason(s) for the requested amendment. We may deny your request for amendment under certain circumstances. If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial. You have the right to submit a written statement disagreeing with the denial which will be included in your health record.

5. ***Right to an Accounting of Disclosures.*** You have the right to request an accounting of certain disclosures of your health information. You must submit your request in writing and you must state the time period for which you would like the accounting of disclosure. The accounting will include the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs for completing the accounting.

6. ***Notification of Breaches of Your Health Information.*** You have the right to receive written notification of any "breach" of your unsecured protected health information, as that term is defined in 45 CFR §164.402.

E. Special Regulations Regarding Disclosure of Behavioral Health Care, Substance Abuse Treatment and HIV-Related Information

For disclosures concerning certain health information such as HIV-related information or records regarding substance abuse or behavioral health treatment, special restrictions apply. Generally, we will disclose such information only with an Authorization that specifically permits the disclosure of such information, or as otherwise permitted or required by law.

F. For Information About This Notice or to Report A Concern Regarding Our Privacy Practices

1. If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington D.C. 20201.

2. To file a complaint with us, you should contact:

   Privacy Officer
   Community Health Center, Inc.
   575 Main Street, 2nd Floor
   Middletown, Connecticut 06457
   Tel: 860-347-6971 (3705)

3. We will not retaliate against you in any way for filing a complaint against CHCI.