School-Based Health Center Medical Locations

Eastern Greenbrier	Greenbrier East	Midland Trail	Summers County	Meadow Bridge
Western Greenbrier	Greenbrier West	Rupert Elementary	Rainelle Elementary	Mobile Heath Unit

Student Name: ______________________ **School Name:** ______________________

Rainelle Medical Center School-Based Health Center Enrollment Form

Rainelle Medical Center (RMC) is pleased to offer primary care (non-sick medical visits) and/or urgent medical care, behavioral health counseling, health education, allergy injections (prescribed by an ENT), vaccinations, and laboratory services to students enrolled in school-based health. In order for your child to receive School-Based Health Center (SBHC) services on their school campus, **all pages** of a SBHC enrollment consent must be **completed, signed, and returned to the SBHC or to the school office**. Although a completed consent will serve for the **entire duration** that your child attends a school that RMC provides medical services and/or behavioral health services, **a completed update form is required with each new school year**.

What is a School-Based Health Center (SBHC)?

- A School-Based Health Center is a satellite medical office of Rainelle Medical Center located on the school campus. The SBHC provides students with medical, behavioral health, and health education services. School-Based Health Centers work to improve the health of students, increase student access to health care, and decreases the amount of your child's lost instructional time and the parents' absence from work. Students are not considered absent from school for the time spent at the SBHC.
- If you have a family doctor, your child can still use the SBHC. You may find it convenient for your child to receive urgent medical care if he/she become sick or injured at school.
- **Completion of this form is required for your child to receive any care at our SBHC**. You can select the services that you wish for your child to receive. *If there is a service we offer that you do not want your child to receive, simply write it on the health information sheet.* A separate consent must be signed for your child to receive vaccinations. You can make changes to your child's consent anytime.
- Rainelle Medical Center will bill your private insurance, Medicaid, or Chips for school-based health services rendered. Uninsured students will not be turned away. Rainelle Medical Center offers a sliding fee-scale for uninsured qualifying patients.
- Rainelle Medical Center provides after-hour, **non-emergency** phone coverage for all School-Based Health Center patients seven days a week. For after hour concerns, you may call (304)438-6188.

Student (Patient) Information

Child's Name: ______________________ ____/____/____ ____/____/____ ____
(please print your child's name as it appears on their birth certificate) Date of Birth Social Security Number Grade

Mailing Address: ______________________

Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Other: ________ **Ethnicity:** ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Intersex ☐ Other____________

Parent/Legal Guardian Information

______________________	______________________	____/____/____	____/____/____
Parent/Guardian Name (please print)	Relationship to Child	Date of Birth	Social Security Number
______________________	______________________	____________	____________
Email Address	Home Phone Number	Cell Phone	Work Phone Number

Parent/Guardian Signature: ______________________ **Date:** ____________

Please list any individual other than yourself who we can contact in case we are unable to reach in an emergency:

Name: ______________________ Cell Phone: ______________ Relationship: __________

Name: ______________________ Cell Phone: ______________ Relationship: __________

Please list any individual other than you and your child who we may speak to about your child's health care:

Name: ______________________ Cell Phone: ______________ Relationship: __________

Name: ______________________ Cell Phone: ______________ Relationship: __________

Insurance Information. Please include a copy of the front and back of your insurance(s) card

Name of **Primary** Insurance Company ______________ Policy/ID Number ______________ Group Number ______________

Billing Address ______________ Phone Number ______________

Insured's Name ______________ Insured's Date of Birth ______________ Social Security Number ______________

Name of **Secondary** Insurance Company ______________ Policy/ID Number ______________ Group Number ______________

Billing Address ______________ Phone Number ______________

Insured's Name ______________ Insured's Date of Birth ______________ Social Security Number ______________

Other Insurance. Please check the box that may apply. ☐ No Insurance; requesting application for the sliding fee scale

☐ Medicaid MA ID Number: ______________ ☐ Molina ☐ Unicare ☐ Aetna Better Health ☐ The Health Plan

☐ WV CHIP Name on Card: ______________________ Policy Number: ______________

Consent to render medical services; permission to bill for services and forward records, and HIPAA.
I, the parent/guardian of the above said student, give consent for him/her to receive health services listed on this SBHC enrollment form. I understand those services may include nursing care, medical treatment, referral for counseling, or behavioral health counseling; and that **all healthcare information is strictly confidential**. Routine information that is a part of school health record may be shared with the school nurse or counselor. By signing this consent below, you are giving the SBHC, school nurse/counselor, and your child's medical doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that the information will continue to be treated in a confidential manner. I give Rainelle Medical Center permission to communicate information with school personnel and to obtain acceptance by a referral physician, as needed. I understand I may withdraw consent at any time by contacting any member of the SBHC staff in writing. I understand that an attempt will be made to notify me of any service rendered to my child either by phone contact or letter. The health center may release information regarding treatment to third party payers for billing purposes. I further authorize the release of any information necessary for processing this claim for the insurance company to pay benefits directly to physician. I also understand that I am responsible for any co-pays, or deductibles set forth by my insurance or if no insurance is billed, I am responsible for payment of any billable service provided to my child. By signing I am agreeing to the statement above.

Child's Name: ______________________/ **Child's Date of Birth:** ______________ **Grade:** ________

______________________/______________________ **Date:** ________

Signature (of the parent/guardian) **Print Name** (of parent/guardian)

Health Information

Does your child have a Primary Healthcare Provider (Doctor): □ Yes □ No

If yes, what is the provider's name: ____________________ Date of last well-child exam: ______________

If your child **does not** have a primary doctor, would you like for Rainelle Medical Center SBHC to become your child's medical home: □ **Yes** □**No**

Would you like for your child to receive their well child physical during the school year: □ **Yes** □ **No**

Would you like for your child to receive behavioral health services? □ **Yes** □ **No**

Does your child have a dentist: □ **Yes** □ **No** Dentist Name: ________________ Last Dental Cleaning Visit: _______

If we need to call in a prescription for your child, which pharmacy would you like for us to use:

Pharmacy Name__________________________ City: ___________________________ Phone:__________

Has your child ever been prescribed an Epi Pen? □ **Yes** □ **No** If yes, please explain: ____________________

Please list any medication or food allergies your child has, and the reaction it causes:

List Food & Medication Allergy	Reaction to the Food or Medication

Has your child had any surgeries or been hospitalized? If yes, please explain the surgery and the date of surgery.

____

List any prescribed medication your child takes daily: (please include over-the-counter medication if taken

Medication:	**Dosage:**	**Reason/Medical Condition:**

Please check the box of any condition listed that your child currently has or previously experienced:

□Anemia	□Asthma	□Bladder or Kidney Infections	□Cancer
□Hepatitis/Liver Disease	□Diabetes	□Endocrine/Gland Disease	□Chicken Pox
□Headaches/Migraines	□Mononucleosis	□Depression/Anxiety	□Pneumonia
□Rheumatic Fever/Heart Disease	□Scoliosis	□Seizures/Epilepsy	□Severe Acne
□Sports Injuries or Fractures	□Stomach Ulcers	□Thyroid Disease	□Tuberculosis
□Digestive Issues ___________	□Seasonal Allergies	□Hyperglycemia	□Bulimia
□Blood Disorder ___________	□Insomnia	□Hypoglycemia	□ADHD/ODD
□Anorexia	□Heart Murmur	□Pregnancy	□Cleft Palate
□Intellectual Disability	□Physical Disability	□Speech Impediment	□Other _____

Does your child have any other health conditions not listed above: □**Yes** □**No** If yes, please explain:

____

PLEASE RETURN A COPY OF YOUR CHILD'S IMMUNIZATION RECORD WITH HIS/HER COMPLETED CONSENT FORM

Health Information Continued

Please check all that apply to your child:

□ Behavioral Issues	□ Anger Issues	□ Severe Lack of Energy	□Test Anxiety
□ Social Anxiety	□ Emotional Issues	□ Performance Anxiety	□ Bullied
□ Self Harm Behavioral	□ Recent Relocation	□ Alcohol Use	□ Drug Use
□ New School	□ Custody Change	□ Living with Grandparent	□ Foster Care
□ Tobacco Use (smoking)	□ Difficulty Sleeping	□ Smokeless Tobacco Use (snuff)	□ Vape Use
□ Loss of Sibling	□ Loss of Parent	□ Terminally Ill Parent/Family Member	□ Bed Wetting

Do you have specific concerns about your child's behavioral health or any additional information that you would like to share? ____

____

Consent to Services Provided by Rainelle Medical Center School-Based Health Center

The School-Based Health Center offers a variety of health care services such as; Physical (Well) Examinations, Immunizations, Sports Physicals, Health Education Services Urgent Care (Illness & Injury), EKG (**if necessary**), Lab Test (strep/flu/urine, etc.), Behavioral Health Counseling, Over-the-Counter Medication, Blood Draws, Covid 19 Test, and Chronic Illness Management. If there is a service that you do not wish for your child to receive, please write it below ____________________.

By signing below, I am acknowledging the above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illnesses, and medications that have resulted in adverse reactions, and a current list of my child's prescribed medications. I, parent/guardian, of the above said child, give consent for my child to receive services by RMC School-Based Health Center without a parent guardian present. I understand this consent will be valid unless I present the SBHC staff with a written and signed request otherwise. Although a yearly update form will be sent, I understand that I am responsible to notify the SBHC immediately if thus said child has any health, medication, address, phone number or guardianship changes.

Signature of Parent/Guardian: ______________________________ **Date**______________

The Health Insurance Portability and Accountability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all physicians and health care facilities to provide patients with a notice describing how and individual's medical information may be used and disclosed, as well as how a patient can obtain access to their information. Please remove the HIPAA attachment on the following page and keep for your record. **My signature is acknowledgment that I have received a copy of RMC Notice of Privacy Practices and Health Insurance Portability and Accountability Act.**

I, ______________________________, whose date of birth is ______________

print parent or guardian name of the minor above

certify that Rainelle Medical Center, Inc. has presented me with a copy of the required notice, mentioned above, in a booklet entitled: "Notice of Privacy Practices."

Signature: ______________________________ **Date:** ______________

Please check one: ( ) Patient ( ) Parent ( ) Guardian ( ) Patient Representative

We are required to collect the following information because RMC is a recipient of federal funding. The information will also determine if you may be eligible for the sliding fee scale or other programs we offer. Your information is strictly confidential and will not be shared.

*Please complete the box below for the **Parent/Guardian** of the student*

Name ______________________	**Date of Birth** ______________________
County of Residence _______________	**Number in Household** _________________
Occupation _______________________	**Annual Household Income $**_____________
	Email:___________________________

Please circle your answer below for the student/patient information

Do you have a medical home? Yes No

Your medical home provider: ____________________________________

Marital Status: Single Married Divorced Widowed Separated	**Employment:** Full time Part Time Not Employed Self-employed Retired Military Duty
Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian White Refused to Report/Unreported Other Pacific Islander More than one race	**Ethnicity:** Hispanic or Latino Not Hispanic/Latino **Language:** English Spanish Other
Veteran? Yes No **Migrant?** Yes No **Seasonal?** Yes No	**Homeless?** Yes No **Homeless Status:** Not Homeless Homeless Shelter Transitional Doubling up Street Other
Sexual Orientation: Lesbian, Gay or Homosexual Straight or Heterosexual Bisexual Something else Don't know Choose not to disclose	**Public Housing?** Yes No **Gender Identity:** Male Female Transgender Male/Female-to-Male Transgender Female/Male-to-Female Other Choose not to disclose

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS, HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

A federal regulation, known as the "HIPPA Privacy Rule," requires Rainelle Medical Center, Inc. (RMC) to provide detailed notice in writing of our privacy practices. We know this notice is long; however, the HIPPA Privacy Rule requires us to address many specific things in this Notice.

Note:

In this Notice, we describe the ways we may use and disclose your health information. The HIPPA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "protected health information" or "PHI". This Notice describes your rights as our patient and our obligations regarding the use and disclosure of your PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Comply with the terms of our Notice of Privacy Practices currently in effect.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit our clinic, a hospital, referral physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among many health professionals who contribute to your care
- legal document describing the care you received
- tool with which we can assess and continually work to improve the care we provide and the outcomes achieved
- means by which you or a 3rd party payor can verify that services billed were actually provided.
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- understanding of what is in your record and how your health information is used to ensure its' accuracy, better understand who, what, when, and why others might access your health information, and make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the property of RMC, other health care practitioners, or facility that compiled it, the information belongs to you. Within specific limitations of federal regulations, you have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect your health record and request a copy of your medical record (a cost-based fee will be applied)
- request to amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use of disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES:

RMC is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

OUR USES AND DISCLOSURES:

We may use and share your information:

- to run our practice, improve your care, and contact you when necessary
- for your treatment
- to bill and get payment from health plans or other entities
- for situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, preventing or reducing a serious threat to anyone's health or safety, and reporting suspected abuse, neglect, or domestic violence
- to comply with the law, respond to lawsuits and legal actions, work with a medical examiner or funeral director, and address workers' compensation, law enforcement and other government requests