HealthPoint Family Care | Locations in Newport, Covington & Florence
Extended Hours & Walk-Ins

Enroll Today for the 2023/2024 School Year Erlanger / Elsmere Schools

Student Name:_____ **Date of Birth:**_____

The HealthPoint School Based Health Centers (SBHC) are a safe and easily accessible place on school grounds where students can go for comprehensive preventive and primary health care services. The SBHC is staffed by a Nurse Practitioner and a School Nurse. The SBHC does not intend to replace your child's primary care provider but these services will help to address the gaps families may have accessing necessary healthcare.

HealthPoint Family Care is pleased to partner with Erlanger/Elsmere Schools to provide onsite healthcare to your children on the campus of Lloyd High School and Tichenor Middle School and at Howell, Lindeman, Arnett and Miles Elementary Schools. The health centers are open to all Erlanger/Elsmere students.

Enrollment in the school based health services is optional. You can enroll at any time during the school year by calling your school nurse. Please complete the attached paperwork and return to your school if you want to enroll today.

Before receiving services the following paperwork must be completed and turned in to the school. Please note that these forms are required to be updated annually. Any incomplete forms will be returned to you.

Health Center Fees for Medical Visits:

- ➔ All **Uninsured patients** will be billed **$23** for their visit.
- ➔ All **Commercial patients** will be billed **$55** for their visit unless they have an Anthem, United Healthcare, Tricare or Humana plan that does not have a required PCP or with a HealthPoint Provider as the PCP and then HealthPoint will bill you for your cost sharing responsibility. There is an additional charge for immunizations for commercially insured patients for plans not accepted at the school
- ➔ **Medicaid** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date. Medicaid copays will be billed.

Dental Center Fees:

- ➔ All **Uninsured patients** will be billed up to **$30** for each visit (with maximum fee of **$120** to complete all treatment and/or repair during the current school year).
- ➔ **HealthPoint bills Anthem Dental, Delta Dental and Dental Care Plus** and you will be billed for your cost sharing responsibility**.** All patients with other private dental insurance will be billed at the HealthPoint full fee schedule rate.
- ➔ **Medicaid** will be billed directly for Medicaid patients as long as a Medicaid ID number is provided and active on the visit date. Medicaid copays will be billed.

The **School Based Health Center** can provide many services including:

- Well-child exams, school physicals, sport physicals
- Sick visits, prescriptions
- Immunizations –info at https://www.cdc.gov/vaccines/schedules/index.html and https://www.cdc.gov/vaccines/hcp/vis/index.html
- Over-the-counter medications (ie: Tylenol)
- Assistance in management of chronic illnesses
- Providing and/or connecting students with mental health services
- Vision screenings
- COVID vaccines are not available in the school. Call 655-6100 to schedule an appointment in a HealthPoint office.

Many **dental services** are available on the campus of Tichenor and Lloyd:

- Comprehensive Exam
- Cleanings
- Fluoride and Sealant Treatments
- Most dental procedures performed in a dental office
- Over-the-counter medications (ie: Tylenol) for dental pain

The **School Based Health Center** is only available at designated times during the school year –ask the school nurse for more information on days and times. HealthPoint's dental office in Covington and Florence is always open on weekdays from 9am-3:00pm and some Saturday's from 9am-3pm. HealthPoint's medical offices are open to 7:30pm on weekdays and to 4:30 pm on Saturdays with same day appointments and walk-in services. Call 655-6100 to make an appointment or walk-in.

If you have any questions, please contact your child's school. *Thank you for allowing us to serve you and your student.*

School Based Health Center Permission Slip: **Child Name:_____DOB_____**

I want to enroll my child in the following program(s) ***(checkmark one or more services below)***

☐ Medical- physicals, sick visits, medicine ☐ Dental Full Services – cleanings, x-rays & treatment ☐ Dental–Emergency Only

Medication Notice: ***Children enrolled for dental will receive over-the-counter medications (ie: Tylenol) for dental related pain***

INITIAL EACH LINE FOR SERVICE YOU WANT CHILD TO RECEIVE AT SCHOOL

_____ WELL CHILD EXAMINATION/PHYSICAL EXAMINATION

_____ Administer all Vaccines as required for school attendance

Please notebelow if any of the vaccines in the box should not be given and give an explanation:

Required for School Entry
Dtap –4 doses Varicella -2 doses
Polio –3 doses Hepatitis A – 2 doses Hepatitis B-3 doses MMR -2 doses

Additional requirements for Preschool and Kindergarten
Pneumococcal and Hib

Additional requirements for 6th Grade and Older
Meningitis and Tdap
Second dose of Meningitis required at age 16

Children on a catch up schedule may have different requirements based on age at time of vaccines administration.

INITIAL FOR EACH RECOMMENDED VACCINE YOU WANT YOUR CHILD TO RECEIVE AT SCHOOL

_____ HPV (Human papillomavirus Vaccine) – 2 doses recommended for students age 11-14, 3 doses recommended for students age 15 and over

_____ Flu Vaccine – Seasonal availability

_____ Meningicoccal B – 2 doses recommended for **ages 16-23** or children over age 10 at increased risk for Meningitis

Authorizations – Consent to Treat a Minor Child (see Page 4)

I certify all information in this packet is correct, and that my signature below constitutes my authorization for purposes of all statements and information contained in this packet. I hereby consent to treatment including whatever test or procedures may be directed by the medical or dental provider. I also consent to all state-required immunizations. I authorize HealthPoint Family Care, Inc. to bill my insurance for services rendered. I further authorize the release of my medical and/or dental information to my insurers or responsible party. I understand that I will be responsible for all bills if there is not active Medicaid, Medicare or private insurance. I authorize HealthPoint to release health records to the school as required for enrollment, including school physicals and immunization records. I understand it is my responsibility to notify the school-based health office about changes in guardianship, home address, or any phone number. A new form must be filled out for any changes in permission status for the "Consent to Treat a Minor Child" portion of this packet. I understand that HealthPoint uses a single, shared medical record for all departments and offices, and therefore any treatment, including substance abuse or disorder treatment, is available to every HealthPoint provider caring for myself or my child for any reason.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (Page 4), I acknowledge by signing below that I have access to the Notice of Privacy Practices at www.healthpointfc.org or can request a written copy using the contact information in this packet.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF VACCINE INFORMATION STATEMENTS (Page 4)
Federal law requires that healthcare staff provide or advise how to download or view a copy of Vaccine Information Statements to a patient, parent, or legal representative before each vaccine, and before each dose of specific vaccines if more than one dose is given in a series.

I acknowledge by signing below that I have been made aware of where to obtain vaccine resources and the most recent Vaccine Information Statements prior to my child (or myself if over 18) being administered vaccines in the school-based health clinic.

Enrollment for the 2023/2024 School Year

Signature of Parent/Guardian:_____ Date:_____

Printed Name of Parent/Guardian:_____

HealthPoint Family Care | Locations in Newport, Covington & Florence Extended Hours & Walk-Ins

Grade ____ Circle one: Lloyd Tichenor Howell Lindeman Miles Arnett Bartlett

Student Name:_____ **Date of Birth:**_____ **Male / Female**

Address:_____ **Social Security #:**_____

City/Zip:_____ **Preferred Language:** English_____ Spanish _____

Other:_____

You agree we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Home Phone Number:_____ **Parent Cell Phone Number:**_____

Parent Work Phone:_____ ***Parent Email Address:**_____

** A "My Chart" account will be created for children age 0-11 if you provide an email address. A PIN number to activate your "My Chart" feature and instructions will be sent home in a sealed envelope with your student. For more information call 859-655-6104.*

Race (select all that apply): [ ] Asian [ ] White [ ] American Indian/Alaska Native [ ] Black/African American [ ] Other Pacific Islander [ ] Native Hawaiian

Ethnicity: [ ] Hispanic [ ] Non-Hispanic

Identifies as: [ ]Male [ ]Female [ ]Male to Female [ ]Female to Male [ ]Neither exclusively male or female [ ]Choose not to disclose

Sexual Orientation: [ ]Straight or heterosexual [ ]Lesbian, gay, or homosexual [ ]Bisexual [ ]Don't know [ ]Choose not to disclose

Your Relationship to Child: [ ] Parent [ ] Foster Parent [ ] Legal Guardian

PARENT OR GUARDIAN INFORMATION:

Name:_____

Address:_____

City / Zip:_____

BILLING TO INFORMATION:

Check here [ ] if same as Parent/Guardian

Name:_____

Address:_____

City / Zip:_____

Please list your total household annual income

$ _____ # of People in Home _____

Income information is collected to support having health and dental programs in the schools. All district students are eligible.

My child has (Check All That Apply):

NO insurance [ ]

Private medical insurance [ ] ***circle if:*** **Anthem/UHC/Humana/Other ID #:**_____ Group #_____PCP:_____

Private dental insurance [ ] ***circle if:*** **Anthem/Delta Dental/Dental Care Plus ID #:**_____ Group #_____

Medicaid [ ] **MCO Name:**_____ **ID #:**_____

A billing statement for private insurance, Medicaid (if payment required) and self-pay patients will be mailed to the billing information address above. Payment is expected in 20 days.

Consent to Treat A Minor Child

HealthPoint providers are authorized to examine and treat the minor child for simple illnesses or routine physicals including immunizations without a parent or guardian being present at the office or school health center.

My signature on the signature page consents for ongoing assessment/evaluation/treatment of my child at HealthPoint offices, including school health centers. Evaluation and treatment of the child at the office will be done by a regular HealthPoint Provider. I give consent for the following dental, physical and/or mental health services to be performed at HealthPoint including school health centers:

- Assessment, diagnosis, evaluation, and treatment of the child even if a parent or guardian cannot be present
- Treatment of the child may include administration of any over-the-counter medications (e.g., pain relievers, cough suppressants, etc.) except the following: _____
- Routine lab work such as a strep screen or urine check.
- Routine immunizations as required by the State.
- Routine physicals, acute illness, follow ups
- Dental exam and procedures including x-rays, sealants, extractions, fillings, drilling, dental hygiene (amalgam or composite), and administration of local and topical anesthetic

The parent or guardian will be contacted for permission before additional things may be done. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

The following person(s) listed have my permission to bring/send my child to the school health center office for treatment:
The School Nurse, Teacher, School Administration and other school personnel may send my child for school based health services, or the parent or student, if age 18 or older, can contact HealthPoint or the school to schedule an appointment.

If you authorize anyone else to bring your child for services (i.e. grandparent, friend, etc.) - Please Print Name and relationship to child):

_____

Release of Information

To promote continuity of care, I authorize HealthPoint Family Care to release a copy of records created at school based health visits to the primary care provider listed below and any other health care provider involved in the patient's care.

Primary Care Provider (PCP):_____ PCP Phone:_____

Vaccine Resources Acknowledgement

If you wish to receive more information regarding required and recommended vaccines you may contact HealthPoint directly by calling 859-655-6104 or visit the website of the Centers for Disease Control and Prevention (CDC) at www.CDC.gov. You may view or print an immunization schedule to be aware of which vaccines your child should receive from ages 0-18 as well as recommended adult vaccines by visiting https://www.cdc.gov/vaccines/schedules/index.html.

The CDC also provides Vaccine Information Statements (VISs) which are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to vaccine recipients. You may view or print the most current VISs at https://www.cdc.gov/vaccines/hcp/vis/index.html.

Go to www.healthpointfc.org to see HealthPoint's Privacy Policy and Nondiscrimination Notice. Contact HealthPoint using the contact information below for a written copy.

Katie Pursifull
HR and Compliance Office
HealthPoint Family Care
215 E. 11th St.
Newport, KY 41071
859-655-6141

Patient Name:_____ Date of Birth:_____

Primary Care Provider Name:_____ Phone Number:_____

Dentist Name:_____ Phone Number:_____

Social History:

Patient's history has been provided by: (Name) _____

Relationship to patient: ( )Mother ( )Father ( )Grandmother ( )Grandfather ( )Caretaker ( )Other - _____

Child's parents are:

( ) married and living together
( ) separated not living together
( ) divorced not living together
( ) other:_____

Who is the Primary Caretaker:

( ) mother
( ) father
( ) grandmother
( ) grandfather
( ) other - _____

Custody Arrangements:

( ) mother is the custodial parent with standard visitation with father
( ) father is the custodial parent with standard visitation with mother
( ) parents have joint custody with shared parenting time
( ) mother is the custodial parent with little or no visitation with father
( ) father is the custodial parent with little or no visitation with mother
( ) grandparents have custody of the child
( ) foster care
( ) other - _____

How is the child doing in school? ( ) well ( ) poorly or not well

Absent from school this year # _____ of ( ) days ( ) weeks ( ) months

Does the child live in a home built before 1970? ( ) Yes ( ) No

Does anyone who lives with the child smoke? ( ) Yes ( ) No

If yes, whom? ( ) mother ( ) father ( ) grandmother ( ) grandfather ( ) Other - _____

Has the child ever been physically abused? ( ) Yes ( ) No

Has the child ever been sexually abused? ( ) Yes ( ) No

Is there a gun in the home? ( ) Yes ( ) No

If yes, is the gun stored in a secure, locked location? ( ) Yes ( ) No

Does the child smoke, use smokeless tobacco or vape? ( ) Yes ( ) No

If "Yes" ( ) Cigarette - Amount ____ pack(s) per #___ ( ) day ( ) week for #___years

( ) Smokeless – Amount ____ can(s) per #___ ( ) day ( ) week for #___years

( ) Vape - Amount ____ cartridge(s) per #___ ( ) day ( ) week for #___years

Any concerns about drugs or alcohol? ( ) Yes ( ) No

Family History of: (Please check all that apply)

( ) Alcohol/Drug Abuse	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Asthma	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Cancer	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Stroke	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Diabetes	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Heart disease	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Heart attack before age 50	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) High Blood Pressure	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) High Cholesterol	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Lead poisoning	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Mental Illness	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Seizure or epilepsy	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Sickle Cell	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Suicide	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Thyroid Disease	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Other:_____	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother

Patient Name:_____ Date of Birth:_____

Family Health:

Mother's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Father's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Guardian's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Child's Medical History:

Does your child have any allergies? If yes, list all allergies and reactions (examples -medicines, pollens, food, stinging insects):

( ) Yes ( ) No_____

List past and current medical conditions: _____

_____

Has your child ever had surgery? If yes, list all past surgical procedures:

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional):

_____

_____

What pharmacy do you use?_____Location/Phone #:_____

Is your child seeing a specialist? ( ) no ( )yes – please explain:_____

Do you have any medical concerns for your child? ( ) no ( )yes – please explain: _____

Do you have any dental concerns for your child? ( ) no ( )yes – please explain:_____

ERLANGER/ELSMERE SCHOOLS

THE ERLANGER ELSMERE SCHOOL DISTRICT
CONSENT TO SHARE INFORMATION
WITH AN OUTSIDE AGENCY OR PERSON

_____ Date of Birth:_____
Student Name

_____ Phone:_____
Street Address

_____
City, State, Zip Code

X **I hereby authorize the Erlanger Elsmere School District to communicate/share information with the following individual or agency. I understand that the information that may be shared may be protected by HIPAA as a protected health record or by FERPA as a confidential educational record. This information is being shared for the purpose of two way communication for exchange of information for treatment planning and progress.**

S **Health and Safety**

HealthPoint Family Care
Name of Individual or Agency
1401 Madison Avenue
Street Address
Covington, KY 41011
City, State, Zip Code

I understand that this authorization for release/invitation is voluntary and that I may revoke it at any time by my written notice. Unless revoked by me, and in writing, this authorization for release/invitation shall be in full effect until. If no date is listed, this release shall be in effect for one (1) calendar year from the date signed. Any revocation will have no effect on prior disclosures granted in accordance with and in reliance upon this authorization for release/invitation. I understand that information disclosed by my authorization may be re-disclosed by this agency or individual only through the process set out in the Family Educational Rights and Privacy Act (FERPA).

_____ _____
Signature of Parent/Legal Guardian
(Student must sign if over 18 years of age)
Date

_____ _____
Signature of Witness
Date

Please Fax a copy of this completed form to Shawn Neace at (859) 727-5653
500 Graves Avenue, Erlanger, Kentucky 41018