

North Beach SBHC Registration Packet

Please know that your child can use the North Beach School-Based Health Center and see your other doctors. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

1. Patient Information and Demographics

Last Name:		First Name:		Preferred Name:	
Date of Birth:		Birth Sex:	Current Gender:	Preferred Pronouns:	
Street Address:			City:	State:	Zip:
Mailing Address (if different than above):					
Email:			Phone: May we text this number? ☐ y e s ☐ n o		
Race or family background (check all that apply): ☐ American Indian/Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black/African America ☐ White ☐ Decline to answer ☐ other: _____					
Hispanic or Hispanic-Latino: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer					
Preferred Language:			Would you like an interpreter for appointments? ☐ Yes ☐ No		

2. Parent/Guardian Information (Complete if Patient is Less than 18 years old)

Last Name:		First Name:		Relationship to Patient:	
Date of Birth:		Sex (Assigned at Birth):		Preferred contact: (select one) ☐ Phone ☐ Call ☐ Text ☐ Email	
Email Address:		Phone:			
Mailing Address (if different from patient's):					
Preferred Language:		Would you like an interpreter for appointments? ☐ Yes ☐ No			
Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self Employed ☐ Retired ☐ Student ☐ Active ☐ Military Duty ☐ Full-time Caregiver ☐ Not Employed ☐ Decline to answer					
Who Does the Student Live With: _____ Who Will Make Healthcare Decisions for This Student: _____					

3. Emergency Contact (Must be age 18 or older) ☐ same as parent/guardian above

Last Name:		First Name:	
Phone Number:		Relationship to patient:	

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4. **Primary Healthcare Information (if applicable)** – we can use this information to coordinate care between the SBHC and your primary doctor.

PCP Name: _____ **Preferred Pharmacy:** _____

5. Insurance Information

- ☐ I do not have health insurance and would like to receive insurance enrollment assistance __ Yes __ No
- ☐ I have recently applied for health insurance and awaiting coverage verification
- ☐ Yes, I have health insurance (*please select and fill out one or more options below*)

☐ **Apple Health Insurance (Medicaid)**

ProviderOne Member Card ID (nine-digit number followed by WA): _____

Managed Care Plan: _____ Plan Phone number (on back of card): _____

☐ **Primary Insurance**

Plan Name: _____ Phone Number (from back of insurance card): _____

Policy Number: _____ Group Number: _____

Subscriber/Policy Holder Name: _____ Relationship to Insured: _____

DOB: _____ Gender: _____ SSN: _____ Phone: _____ Email: _____

Mailing Address: _____

☐ **Additional Insurance**

Plan Name: _____ Phone Number (from back of insurance card): _____

Policy Number: _____ Group Number: _____

Subscriber/Policy Holder Name: _____ Relationship to Insured: _____

DOB: _____ Gender: _____ SSN: _____ Phone: _____ Email: _____

Mailing Address: _____

- I confirm that the above information is true and correct to the best of my knowledge. I understand that any deliberate misrepresentation of the information may cause me to be responsible for the full charge of services delivered.
- I agree that this authorization shall remain in effect for as long as the student is enrolled in North Beach School District unless the consent is cancelled by written notice.
- I authorize the release of any medical information necessary to process my claims and I authorize payment of medical benefits to the supplier for services described on the claim form/superbill.
- I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me.
- I understand that this program is supported by a Washington State Department of Health grant. In accordance with the grant guidelines, de-identified patient information will be reported including the total individuals served, demographic information, total services provided, and program performance.

Signature

Relationship to Patient

Date

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Patient First Name:	Middle Initial:	Last Name:	Date of Birth:

Consent for Health Services

North Beach's School-Based Health Center must have signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access treatment without parent/guardian consent. This consent does not apply to the services provided by the school nurse. Students can continue to receive school nurse services without this consent form.

1. I hereby request and authorize that the student named above receive health care services from the North Beach SBHC providers. Services may include, but are not limited to, routine medical care, naturopathic medical care, mental health services, sports physicals, preventive care, evaluation and treatment of acute illness and injuries, immunizations, laboratory testing, & health education. Consent is also given for referral of care and, if needed, emergency transportation to other hospitals, clinics, or agencies as deemed necessary by the North Beach SBHC care team. This authorization does not allow services to be provided without the student's consent, unless they are unable to consent.
2. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical decisions. If I am unable to be present, authorization is given for my child to receive services in my absence.
3. In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist, for example:
 - a. Permission is given by the patient or parent/guardian through a signed release of information form.
 - b. The patient indicates risk of imminent harm to self or others.
 - c. The patient has a life-threatening health problem and is under the age of 18 years old.
 - d. There is reason to suspect abuse or neglect.
 - e. Certain communicable diseases must be reported to public health authorities.
4. Consent is given to share necessary information with the North Beach SBHC health care team and their colleagues, including between the mental health professional, medical provider, the school nurse and school counselor, for the purpose of providing the best care for the student. To facilitate coordination of care, the student's School-based Health Center health record will be accessible to all SBHC affiliated providers. Consent is granted for the school nurse to administer over-the-counter medications as prescribed by the medical provider of the SBHC.
5. **Notice of Privacy Practices:** I understand North Beach School-Based Health Center Notice of Privacy Practices that describes how the patient's health information may be used and shared with other health care providers and how I can access this information.

Student Signature (age 13 and older): _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Name of Legally Responsible Guardian (Print): _____ **Relationship** _____

IMPORTANT INFORMATION ON MINOR CONSENT: *North Beach School-Based Health Center encourages each student to involve their parents or guardians in health care decisions whenever possible. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Also, starting at age 13, youth may independently receive drug and alcohol cessation services and mental health counseling without parent or guardian consent. Starting at age 14, youth may independently receive testing and/or treatment for HIV and STI's. Because youth may independently receive this care, their consent is legally required for release of information about pregnancy and sexually transmitted infections. Consent from students aged 13 and over and parent/guardian consent for students age 12 and under is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent".*