

Please fully complete this form to help us provide your child with quality care. This consent will remain active from year to year.

Your student's health is an important part of their academic success. In order to support the success of your child, there is a school-based health center (SBHC), operated by Sea Mar, on site available to all students for both in-person and telehealth visits. The SBHC offers all the services of a family doctor and we can provide appointments before, during and after school. Even if your student already has a care provider, we can work closely with them, providing a convenient option for medical, dental and mental health services at the school. Sea Mar is committed to serving all patients regardless of ability to pay. We hope you take advantage of this resource and look forward to seeing you at school.

STUDENT INFORMATION AND DEMOGRAPHICS				
LAST NAME	FIRST NAME	MIDDLE NAME	GRADE	PREFERRED NAME
STUDENT ID NUMBER	DATE OF BIRTH / / MONTH DAY YEAR	BIRTH SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	LEGAL SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	
ARE YOU HISPANIC OR HISPANIC-LATINO?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown <input type="checkbox"/> Unsure If Hispanic: <input type="checkbox"/> General Hispanic <input type="checkbox"/> Mexican/Mexican-American/Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Other Spanish/Hispanic <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Unknown <input type="checkbox"/> Not Spanish/Hispanic			
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian (Cambodian) <input type="checkbox"/> Asian (Chinese) <input type="checkbox"/> Asian (Filipino) <input type="checkbox"/> Asian (Indian) <input type="checkbox"/> Asian (Japanese) <input type="checkbox"/> Asian (Korean) <input type="checkbox"/> Asian (Laotian) <input type="checkbox"/> Asian (Multi-Ethnic) <input type="checkbox"/> Asian (Other) <input type="checkbox"/> Asian (Pakistani) <input type="checkbox"/> Asian (Thai) <input type="checkbox"/> Asian (Vietnamese) <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Declined to answer <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
WHAT IS YOUR ETHNICITY?	<input type="checkbox"/> African – Ethnic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Cambodian <input type="checkbox"/> Black, African America <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Laotian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Not Reported/Unknown <input type="checkbox"/> Other Asian <input type="checkbox"/> Other <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islanders <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> White/Caucasian			
WHAT IS YOUR PREFERRED LANGUAGE?		DO YOU NEED AN INTERPRETER?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE YOU CURRENTLY LIVING IN A SHELTER, IN YOUR CAR, A HOTEL OR ON THE STREET?	<input type="checkbox"/> Yes <input type="checkbox"/> No	AT ANY POINT IN THE LAST TWO YEARS, HAS SEASONAL OR MIGRANT FARM WORK BEEN YOUR OR YOUR FAMILY'S MAIN SOURCE OF INCOME?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE YOU A VETERAN OF THE UNITED STATES ARMED FORCES?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

STUDENT INFORMATION AND DEMOGRAPHICS CONTINUED**MAILING ADDRESS**

STREET	CITY	STATE	ZIP CODE
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HOME ADDRESS (IF DIFFERENT)

STREET	CITY	STATE	ZIP CODE
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MARITAL STATUS

<input type="checkbox"/> Divorced	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Married	<input type="checkbox"/> Other
<input type="checkbox"/> Separated	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	

STUDENT CONTACT INFORMATION

STUDENT PHONE NUMBER	<input type="checkbox"/> Home <input type="checkbox"/> Cell	STUDENT EMAIL ADDRESS
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COMMUNICATION COMMENTS:

<input type="checkbox"/> Call Anytime-Leaving Message is OK	<input type="checkbox"/> Call Mornings Only-Leaving Message is OK
<input type="checkbox"/> Call Anytime- Never Leave Message	<input type="checkbox"/> Call Mornings Only-Never Leave Messages
<input type="checkbox"/> Call Evenings –Leaving Message is OK	<input type="checkbox"/> Never Call
<input type="checkbox"/> Call Evenings -Never Leave a Message	

EMERGENCY CONTACT INFORMATION #1

LAST NAME	FIRST NAME
PHONE NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____

EMERGENCY CONTACT INFORMATION-ALTERNATIVE

LAST NAME	FIRST NAME
PHONE NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____

INSURANCE

DO YOU HAVE INSURANCE?	<input type="checkbox"/> Yes <input type="checkbox"/> No	INSURANCE TYPE <input type="checkbox"/> Medicaid/Provider One/DSHS <input type="checkbox"/> Other <input type="checkbox"/> Self-Pay/Uninsured <input type="checkbox"/> Private Insurance
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE	EFFECTIVE DATE
	GROUP PLAN NUMBER	MEMBER ID #
	SUBSCRIBER/POLICY HOLDER NAME	SUBSCRIBER DATE OF BIRTH

MEDICAL SERVICES INFORMATION

WHO IS YOUR PRIMARY PHYSICIAN?	WHAT CLINIC ARE THEY AT?
WHO IS YOUR DENTIST?	WHAT CLINIC ARE THEY AT?

CONSENT FOR HEALTH SERVICES

Sea Mar’s school-based health center is located at Options High School in the Bellingham School District. Sea Mar must have a signed consent from a parent or legal guardian before providing services, except in situations where federal or state laws allow the student to access treatment without parent/guardian consent. Students do not need to be registered at the health center to receive services from the school nurse.

STUDENT LAST NAME	STUDENT FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH / / MONTH DAY YEAR	STUDENT ID #
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CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to this clinic is currently correct and understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical, Mental Health, and Dental staff of the above named clinic to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my child’s health problems. I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by licensed Mental Health Therapist or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is cancelled by written notice to the clinic. The assignment and release authorizes Sea Mar to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. 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 agree to pay all charges that are not paid in full by assigned insurance.

NOTICE OF PRIVACY PRACTICES: I understand that Sea Mar’s Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information is available to me at the location my child receives their school based health care and on the Sea Mar website at <http://seamar.org>.

Student Signature: (Required for 13 and older)	Date:
Parent/Guardian Signature:	Date:
Name of Legally Responsible Guardian: (please print)	Relationship:

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the School Based Health Center will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages students to involve their parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, 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”.



AUTHORIZATION FOR RELEASE OF RECORDS

DATE: _____

STUDENT: _____

BIRTHDATE: ___/___/___

SCHOOL: _____

DATE OF REQUEST: ___/___/___

I hereby authorize the release of records:

	FROM			TO
Name of agency/person	Bellingham Public Schools (Options High School)		Name of agency/person	SeaMar Community Health Centers - Bellingham
Address	1985 Barkley Blvd		Address	4455 Cordata Parkway
City, State, Zip	Bellingham, WA 98226		City, State, Zip	Bellingham, WA 98226
Telephone	360-676-6400		Telephone	360-671-3225
FAX			FAX	

Describe the records to be disclosed:

Education records, including attendance

The reason for disclosing the records is for education planning. If for other reason, please explain:

Communication with school-based health center

I understand that the information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from ___/___/___ to ___/___/___.

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian signature

_____/_____/_____
Date



Notice of Privacy Practices Acknowledgement

The Notice of Privacy Practices for Protected Health Information describes how Health Records about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

Sea Mar has the responsibility to protect the privacy of your information, provide a Notice of Privacy Practices, and follow information practices that are described in this notice. If you have any questions, please contact Sea Mar's Vice President of Corporate and Legal Affairs at 206.763.5277.

By signing this form, you acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities. Sea Mar encourages you to review these notices carefully.

I acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal represent

Financial Screening Form

To comply with federal regulations and provide you a discount on Sea Mar services, it is necessary for you to fill out this form, answer some personal questions, and provide proof of income. Your answers will be kept on file and in strict confidence.

Patient Name:	DOB:	Patient ID:
Household Size:	Annual Income:	<input type="checkbox"/> I choose NOT to provide my income.

I choose **NOT** to apply for the sliding fee scale. Please sign and date below.

Signature

Date

I choose to apply for the sliding fee scale discount. The sliding fee scale is available for all patients, regardless of insurance status. If you have insurance, the sliding fee scale discount can be applied to charges not covered by insurance. Please complete the entire form to determine eligible discount.

Household Members	NAME	BIRTHDATE (MM/DD/YYYY)	HEALTH INSURANCE	RELATIONSHIP	SEA MAR PATIENT?	
	1					
	2					
	3					
	4					
	5					

SOURCE OF INCOME	ANNUAL INCOME	For You	For Spouse	For Children	For Others	Sub Total
	Gross Wages, Salaries, Tips					\$ 0.00
	Social Security & Pensions					\$ 0.00
	Annuity & Veteran Benefits					\$ 0.00
	Child Support & Alimony					\$ 0.00
	Self-Employment & Other					\$ 0.00
	For "Other," please explain:					
TOTAL					\$0.00	

By signing below, I agree to provide Sea Mar Community Health Centers with a proof of income for all persons listed above. Acceptable proof of income includes, but is not limited to, social security statements, paycheck stubs (two most recent), public assistance letter, tax return form, W-2 form, L&I check stub, unemployment check stub.

I understand that I will be asked to reapply for the sliding fee scale at least once a year so Sea Mar can maintain an updated application on file. I certify that the information provided is accurate and complete to the best of my knowledge. I understand that if I knowingly give false information that results in assistance for which I am not eligible, I will be subject to criminal prosecution. I give my consent to release any and all information from whatever source needed to verify the information I have given.

Signature

Date

OFFICE USE ONLY

Patient is eligible for Sliding Fee Scale: Yes No

SFS Status (circle one): A B C D E F

POI Requested: _____ Initial: _____

POI Received: _____ Initial: _____