Bassett Healthcare Network
School-Based Health

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student Information

Student's Name: Date of Birth: / / ☐ M ☐ F ☐ Other_____

Preferred Name: Student Email:

Home Phone #: Student's Cell #: Social Security #:

Address:

City: Zip: County: Religious Preference:

Student's Mother's Maiden Name:

Primary Care Provider/Address

Pharmacy/Address:

Name of School District: Grade:

Parent/Guardian Information

Parent/Guardian Name: _____ DOB_____ ☐ Mom ☐ Dad ☐ Guardian	Parent/Guardian Name: _____ DOB_____ ☐ Mom ☐ Dad ☐ Guardian
Home #:	Home #:
Work #	Work #
Cell #:	Cell #:
Address (If different than student):	Address (If different than student):
E-Mail:	E-Mail:

Emergency Contact (other than parent/guardian)

Name: Relationship to Student:

Home #: Cell # Work #:

Address:

Health Insurance Information

Does the student have Health Insurance? ☐ Y ☐ N

If yes, please continue. If no, would you like help getting health insurance? ☐ Y ☐N

PLEASE SEND A COPY OF YOUR INSURANCE CARD, BOTH FRONT AND BACK (or stop in and we'll make a copy for you)

Insurance Name: Is this Child Health Plus? ☐ Y ☐ N

Subscriber #/Policy #: Group #: Effective Date:
If there is a two-digit # next to student's name please provide after policy #.

Policy Holder's Name: DOB: SSN:

Employer of Policy Holder: Relationship to Student:

Copay Amounts: **(SBHC does not collect copays)**

Medicaid #: Access #: Seq #:

Effective Date:

ENROLLMENT SBHC

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student's Legal Name: _____ Date of Birth: ___/___/___ Sex: M / F / O

I give consent for my child to receive oral /health care services including telemedicine. I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State law. New York State law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, reproductive health or mental health issues.

I WILL NOTIFY THE SCHOOL-BASED HEALTH CENTER IN WRITING IF I WISH TO REMOVE MY CHILD FROM THE HEALTH PROGRAM.

In order to provide optimal health care to your child, it is necessary for the School-Based Health Center staff and school nurse to regularly communicate and share medical and health related information. I hereby authorize the release of information from the School-Based Health Center to the school nurse and the school nurse to the School-Based Health Center. I understand that the information to be released is confidential and protected from re-disclosure. It will not be released except to the School-Based Health Center or school nurse without a completed authorization to do so. It may also be necessary, if your child is receiving services from a SBHC Mental Health clinician, for information to be discussed with other clinicians in the SBH mental health program as part of the case supervisory process. I understand that any shared information is confidential and protected from re-disclosure.

X _____ Date: ___/___/___

Parent/Guardian Signature

Please be sure to read and sign the authorization below.

***Authorization to release information*:** I hereby authorize and direct The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release to government agencies, insurance carriers, managed care companies or others who are financially liable for my hospitalization and medical care and their authorized agents all information needed to substantiate payment for this hospitalization and medical care and to permit representatives thereof to examine and request copies of records to this care and treatment. This authorization includes information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV-related test, HIV infection, HIV related illness, AIDS or any information which would indicate potential exposure to HIV and any information related to or regarding genetic testing. I further authorize the Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release billing information to any provider involved in my care.

***Assignment of Insurance Benefits*:** I hereby assign and transfer to The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus, and Bassett Medical Group sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependent.

X _____ _____ _____

Signature of Parent/Guardian | Date | Time

ENROLLMENT SBHC

Student's Legal Name: DOB:

Dental Enrollment

Please check all that apply:

☐ No SBHC dental services are requested at this time. My child receives **yearly** dental care.

☐ Yes I would like my child to receive preventative and diagnostic dental care at SBHC.

Date of last dental cleaning/exam/x-rays: MM _____ DD _____ YR _____ need to be 6 months apart for insurance purposes

Dentist Name/Address/Phone: _____

Allergies: _____

If Yes, please sign below:

I give permission for School-Based Health to evaluate my child's teeth at school and if appropriate, provide preventative and diagnostic dental services (cleanings, x-rays and teledental exam, fluoride treatment, sealants).

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

If you would like to be present for the dental visit please call your SBHC or 1-844-255-7242

DENTAL INSURANCE

Dental insurance coverage varies. Most plans will allow for only one cleaning (prophylaxis) and exam **every six months.** Please become familiar with your child's dental insurance coverage in order to avoid confusion with benefit payments.

Please copy both sides of insurance card and send with this form.

☐ We **do not** have **dental** insurance

Insurance Company: _____ Is this Child Health Plus ☐ Yes ☐ No

Phone # of Company: _____ Effective Date: _____

Insurance Co. Address: _____

_____

Subscriber ID #: _____ Group #: _____

If there is a two digit # next to student's name please provide after ID # _____

Legal Name of Policy Holder: _____ Date of Birth ____/____/_____

Social Security # of Policy Holder ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Policy Holder's Mailing Address: _____

_____ Phone # _____

Employer of Policy Holder: _____ Policy Holder's Relationship to child: _____

Does your child have more than one Health Insurance Plan? ☐ Yes ☐ No (If yes please copy card or contact SBHC)

Medicaid ID# ☐☐ ☐☐☐☐☐☐☐☐ Access # _____ Seq# _____

ENROLLMENT SBHC