InterCommunity
Health Care for the Whole Person

InterCommunity School Based Health Centers
Registration and Consent Form

School Name: **Grade:**

Dear Parent or Guardian: Our School Based Health Center is pleased to provide medical and behavioral health services at your child's school during school hours. Please fill out this form and return it to the school with your child to enroll in the program.

Student Information

Last Name	First Name	MI	Date of Birth

Street Address	City	State	Zip	Social Security Number

☐ Public Housing ☐ Homeless: If yes, please specify: ☐ Shelter ☐ Doubling up ☐ Transitional ☐ Other

Home Phone	Cell Phone	Work Phone	Email Address	Emergency Contact Person	Emergency Contact Number

Sex
☐ M
☐ F

Language
☐ English ☐ French
☐ Spanish ☐ Indian
☐ Russian ☐ Other

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Race
☐ Black ☐ White ☐ Asian
☐ American Indian/Alaskan Native
☐ Pacific Islander ☐ Other Pacific Native
☐ Native Hawaiian ☐ Other
☐ Unreported or refuse to report

Parent/Guardian Name ______________________________ Parent/Guardian Date of Birth ______________

Insurance Information

Primary Medical Insurance	Insurance ID/Medicaid ID #	Group #

Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's Social Security #

Income

My Annual Household Income is: ______________ Total # of Dependents in Household (including patient): ______________

I give permission for my child to receive medical and behavioral health treatment/services by InterCommunity School Based Health Centers. I understand that this authorization is valid as long as my child is enrolled in the Manchester School District or until I revoke this authorization with the Program Coordinator at InterCommunity School Based Health Centers.

I hereby authorize InterCommunity to use and disclose my child's protected health information (including both physical and mental health information) for treatment, payment and healthcare operation purposes, including the release of such information to process claims to my insurance company. I authorize direct payment from my insurance company to InterCommunity.

In the event that trained school personnel, such as school nurses or health aides, are not available to give prescribed medications taken routinely at school, I authorize InterCommunity staff to administer such medications to my child.

I consent to receiving phone calls regarding services my child receives or may be eligible to receive and agree to receive a copy of InterCommunity's Notice of Privacy Practices via email at the email address listed above. The Notice of Privacy Practices can also be accessed at www.intercommunityct.org/privacy-practices/).

By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I have read, understand, and agree with each of the above paragraphs and certify that all of the information provided is true and complete.

Signature ______________________________ Date ______________________________

I certify and attest that all of the above information is true and correct. I understand that InterCommunity may verify information on this form. I understand that the financial information will determine eligibility for the Center's sliding fee discount. I also understand that if I intentionally misrepresent my family's income, my child will not be eligible to receive services at a discounted rate. I understand that if my child is uninsured, my fee will be based on a sliding fee schedule. I also understand that I will be financially responsible for all charges incurred.

Signature ______________________________ Date ______________________________

Any protected health information released by InterCommunity that includes information that is protected by special state or federal laws, such as substance abuse treatment and HIV-related information, will be released in accordance with those laws. Please refer to InterCommunity's Notice of Privacy Practices, accessible at www.intercommunityct.org/privacy-practices/, for more information. InterCommunity's Notice of Privacy Practices also explains InterCommunity's ability to make your child's protected health information available to other providers through the Care Everywhere feature. Please contact InterCommunity's Privacy Officer at 860-569-5900 or compliance@intercommunityct.org to learn how to opt in to this convenient way to share your child's information with other providers.