BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

[1]

SCHOOL BASED HEALTH CENTER ENROLLMENT PACKET

Must Be Completed Annually

Hello Parents!

Boston Mountain Rural Health Center, Inc. (BMRHC) is excited to announce that they are partnering again with your child's school district to provide the faculty and students high quality, accessible healthcare with the convenience of not having to leave campus! The BMRHC school based health center's (SBHC) focus is to provide primary and preventive medical and behavioral health care to students and faculty that are enrolled in the SBHC. Enrolling is easy and *FREE*!

In order for BMRHC to provide optimal care it is important that we have current information. Please complete the following information and return to your school.

- ❑ School Based Health Center Enrollment Form
- ❑ Patient Demographic Form
- ❑ Consent To Treat
- ❑ HIPAA Privacy Information
- ❑ Statement of Income
- ❑ Health History
- ❑ Immunization Consent Form

Hours of Operation:

SBHC services are available when school is in session during normal work hours. When it is not in session, you may call 870-448-5733 for assistance with your health needs.

Appointments are available:

- Monday - Thursday 7:45am - 5:15pm and Friday 7:45 am - 11:45 am
- BMRHC also offers after hours on-call services for non-emergent needs outside of normal working hours, holidays, and weekends. The number is 870-448-7222 to reach a highly qualified clinical staff member to assist you.

Cost:

- BMRHC accepts all insurances!
- A Sliding Fee Program is available where your child can receive a comprehensive exam for as little as $10.
- BMRHC also can connect you or your child with someone who can assist you with enrolling in free or low cost health insurance.

[1] Updated: 5/28/24

We suggest that you periodically check our Facebook page or website (www.bmrhc.net) for updates and new information. We look forward to an exciting, healthy year!

SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

School District:_____**Campus:**_____

Grade:_____ **Graduation Year**:_____

Student's Name: First_____ **M.**_____ **Last**_____

Student's DOB: _____

***Please make a selection below:

☐ **YES!** I would like for my child to receive care at the Boston Mountain Rural Health Center School Based Clinic. **If marking yes, Please continue to complete the remainder of this packet.** Services could include treatment for illness or injury, including over the counter medications or necessary prescriptions, well child exams, telehealth appointments, immunizations and emergency services as needed. Please list the best contact number below:

☐ **NO**! I do not wish for my child to receive medical care at Boston Mountain Rural Health Center School Based Clinic. **If signing no, you do not have to complete the remainder of this packet. If your child has emergent needs at the school, care will be provided regardless of the selection on the form.**

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ MI: _____ Last Name:_____

Address: _____City_____ State _____Zip_____

Date of Birth: _____ Social Security #:_____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Employer Name: _____Work Phone: _____

Emergency Contact Name: _____Relationship:_____ Ph #:_____

Primary Care Provider (PCP): _____ PCP Contact Number: _____

Parent/Guardian Name:_____ Address: _____

Parent/Guardian Social Security #_____ Parent/Guardian DOB:_____

Insurance Name: _____ Member ID #: _____ Group #: _____

Subscribers Name: _____

***Please complete the following section IN REGARDS TO THE PATIENT*:**

- **Ethnicity (Circle):** Hispanic or Latino, Not Hispanic, Declined to Specify
- **Race (Circle)**: Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific Islander, Other Pacific Islander, White, Declined to Specify, More than One Race
- **Primary Language (Circle):** English, Indian, Spanish, Russian, Marshallese, Other
- **Marital Status (Circle):** Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown
- **Veteran (Circle):** Yes/No
- **Education Level (Circle):** Some High School, GED, High School Graduate, Some College, College Graduate
- **Communication Needs (Circle):** None, Visually Impaired, Hearing Impaired, Cognitive Impairment
- **Transportation Barrier (Circle):** Yes,No
- **Sex at Birth:** Male, Female
- **Gender Identity (Circle):** Male, Female, Female to Male/Transgender Male/Trans Man, Male Female/Transgender Female/Trans Woman, Genderqueer, neither exclusively male nor female, Choose not to disclose, Additional Gender Category or other
- **Sexual Orientation (Circle)**: Lesbian/Gay/Homosexual, Straight/Heterosexual, Bisexual, Do Not Know, Choose not to disclose, Something Else, please describe_____

*Boston Mountain is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care.

- **Agricultural Worker**: Yes/No *(If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)*
- **Homeless**: Yes/No *(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)*
- **PREFERRED PHARMACY** _____

I hereby certify that the above information is correct.

_____ _____

Patient Responsible Party Signature **Date**

BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

ADULT & MINOR
CONSENT TO TREATMENT/TELEHEALTH CONSENT

_____
Patient Name -PRINT

I hereby consent, myself or to whom I am legally responsible to receive outpatient services provided by Boston Mountain Rural Health Center, Inc. ("BMRHC"), including, but not limited to the examination, diagnosis, and treatment. I understand that this consent remains in effect so long as I am a patient of BMRHC, and I understand I may discontinue services at any time.
Our center requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment.

Complete for Minor, if applicable:
If I am unable to be present for my child's visit, the person(s) listed here is/are authorized by me to accompany my child to their visits and sign any necessary consents or acknowledgements on my behalf, including responsibility for payment. **I understand that individuals that accompany my child Must be 18 or Older.**

Name: _____Relationship: _____
Contact #: _____

Name: _____Relationship: _____
Contact #: _____

Complete for School Based Health Centers:
As the parent/guardian, I grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits and as with other health related matters, health information cannot be released without consent. If sports physicals are completed, I give consent to release to my child's school.

Telehealth/Video Conference Services
I have received a copy, read, and understand the telemedicine guidelines. I agree to participate in the telemedicine consult, in which my image and my Protected Health Information (PHI) will be transmitted electronically through the videoconference(s) to health care professionals that are authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services.

I understand that the software system is encrypted, so the likelihood of this transmission being intercepted by unauthorized persons is EXTREMELY small. I understand that I can withdraw my permission at any time prior to the videoconference and/or my interrupt the videoconference at any time. In either case, I understand that no action will be taken against me, and I may still pursue a consultation in person with a physical or other health care professional. I also understand that if I interrupt the videoconference, the consultation will

be incomplete. Therefore, I understand that health care professionals involved in the video conference will be unable to provide treatment or services to me at that time.

I understand that there are limits to Telemedicine Technology. Therefore, there is no guarantee that this Telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

Notification of Privacy

I have received a copy, read, and understand the BMRHC Notice of Privacy Practices. Please be aware that BMRHC's behavioral health services are designed to provide treatment only. Treatment services offered must be medically necessary. Copies of Independent Licensed Practitioner (ILP) and behavioral health service rules are available to patients upon request.

Authorization to Release Information

I hereby authorize BMRHC to release any necessary information acquired in the course of my examination or treatment to any authorized agent related to treatment, payment, or healthcare operations. I further authorize the ability to view prescriptive history from external sources. I further authorize the release of health information to federal and state governing entities for the purposes of required reporting.

Authorization to Pay Benefits

I authorize the clinic to release medical, dental, behavioral health or other such information to the third party insurance carriers for the purposes of filing insurance claims related to my care and understand that I may be billed for services rendered.

Acknowledgement

I acknowledge that I am responsible for the payment of the account balance. I understand that third party service payments may be denied based on the third-party payer's policies and rules. I agree to be responsible for all amounts not covered by my insurance.

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

Patient Signature or Designated Representative (If minor, Parent or Legal Guardian

Date

BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

HIPAA PRIVACY

HIPAA/Protected Health Information (PHI) Disclosure

_____

Patient Name -PRINT

Boston Mountain Rural Health Center, Inc. (BMRHC) is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization. Please understand that this may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

BMRHC participates in programs, such as the State Health Alliance for Records Exchange (SHARE), CommonWell and CareQuality to share and receive your health information statewide among your doctors, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs. If you wish to opt-out, you must ask your health care provider for and complete an Opt-Out Form. You can also opt-out for your minor child (under the age of 18) using the same process.

In an effort to serve you more efficiently, BMRHC opts patients into an automated system to remind you of appointments, lab notices by portal, health maintenance reminders, prescription confirmation and general notifications. You will be contacted using the latest contact information on file. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. You may opt out at any time.

BMRHC offers access to medical information through the patient portal and/or Healow application. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. I understand that it is my responsibility to let BMRHC know when my email address has changed.

[ ] I wish to Web Enable my account (Patient Portal) **ONLY FOR PATIENTS 18 YEARS AND OLDER**

Email:_____

BMRHC also realizes you may have family members or significant people whom you may wish your provider speak with regarding your healthcare information. Please specify the individual(s) and their relationship to you so that your healthcare team has permission to discuss your Protected Health Information (PHI) healthcare information. It is your responsibility to communicate any changes to BMRHC staff and request an update in your medical record.

Individual's Name	**Phone Number**	**Relationship to You**
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

_____ _____

Patient Signature Or Designated Representative Date

BOSTON MOUNTAIN
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Statement of Income

As a Federally Qualified Health Center, Boston Mountain is required to collect income information on all patients even if you choose not to participate in the Sliding Fee Scale Program. Please choose your household gross annual income range:

[ ] $0 - $11,880	[ ] $11,881 - $23,881	[ ] $23,882 - $34,882
[ ] $34,883 - $45,883	[ ] $45,884 - $56,884	[ ] $56,885 - $67,885
[ ] $67,886 - $77,886	[ ] $77,887 - $88,887	[ ] $88,888 - $99,888
[ ] $99,889 - $110,889	[ ] $110,890 - Above	[ ] Choose not to disclose

Please ask the receptionist for more information on the Sliding Fee Scale Program

Number of Household Members (Including Self): _____

_____ _____

Patient OR Parent/Guardian Signature **Date**

BOSTON MOUNTAIN
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STUDENT HEALTH HISTORY

Child's Name: _____ DOB: _____
Are there any problems that concern you about your child?

_____
_____
_____

Does your child have any **allergies** (food, medication, environmental)? Please list the allergy and the reaction:

_____
_____
_____

Current medications (include vitamins/fluoride/supplements):

1._____Prescribed by:_____
2._____Prescribed by:_____
3._____Prescribed by:_____

Date of last physical examination: _____ By Whom: _____

Date of last dental examination: _____ By Whom: _____

Date of last eye examination: _____ By Whom:_____

List hospitalizations, illnesses, accidents, broken bones, surgeries, etc. Please include Date and Child's age and explain:_____

_____
_____
_____

Please list any specialist that your child currently sees:

1. _____ Location:_____
2. _____ Location:_____
3. _____ Location: _____

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Health History Continued:
Personal History (Patient) **Date:** _____
Name: _____ Date of Birth____/____/_____(mm/dd/yyyy)
Age_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							