Primary HEALTH SOLUTIONS
YOUR FAMILY. YOUR COMMUNITY. YOUR HEALTH.

Hamilton School-Based Health Center Enrollment Packet

OneSight

HAMILTON CITY SCHOOL DISTRICT

PLEASE COMPLETE AND SIGN ALL PAGES.

Patient's Name: _____ **DOB:** _____ **Sex: M __or F___**

Patient's Social Security # _____ **Student School ID#** _____

Student's Current Building_____ **Student's Current Grade** _____

PRIMARY CARE SERVICES:

__ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (includes work, daycare, and sports physicals) appropriate immunizations, and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision and hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate)

__ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school based health center (SBHC)

DENTAL SERVICES:

__ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Primary Health Solutions Clinic or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. (Treatment plan will be approved with parents / guardians prior to starting.)

__ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

VISION SERVICES:

__ **YES,** I consent for my child to receive **VISION SERVICES** at the OneSight Vision Center at Hamilton City Schools, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction.

__ **NO,** I do not wish for my child to receive **VISON SERVICES** at the OneSight School-Based Eye Center

TRANSPORTATION:

__ **YES,** I consent for my child to be **TRANSPORTED/ACCOMPANIED** to and from medical, dental or eye center services by a school designee. I, the parent or guardian of above named student, release Primary Health Solutions, its Board members, employees, and authorized agents and representatives and the Hamilton City School District, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

__ **NO,** I do not wish for my child to be transported to or from school for these purposes.

By signing this consent, I agree to the terms and conditions regarding the PAYMENT FOR SERVICES & SHARING OF HEALTH INFORMATION as explained in the accompanying Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the Program Description form. I have received the **Notice of Privacy Practices**.

_____ _____

Parent/Guardian Signature **Date** **Parent/Guardian's Printed Name**

_____ _____

Patient's Signature (if 18 or older) **Date** **Patient's Printed Name**

(Please continue to the next page)

PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Social Security #	Birth Date	Sex

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (if different)	**City**	**State**	**Zip**

RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient):

Last Name	First Name	MI	Social Security #	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

	Policy #	Group #	Effective	Co-Pay	Policy Holder	Relationship
Primary Insurance						
Secondary Insurance						
Tertiary Insurance						

STATISTICS REQUIRED FOR GOVERNMENTAL REPORTING PRIMARY CARE AND PRIMARY DENTAL PROVIDERS:

Please ☑ Race: ☐ White ☐ Black/African-American ☐ American Indian ☐ Asian
☐ Hawaiian ☐ Pacific Island ☐ More than one race ☐ Other

Please ☑ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Please ☑ to indicate the languages you can speak fluently:
☐ English ☐ Spanish ☐ French ☐ German ☐ Russian ☐ Other: _____
Do you speak English fluently? ☐ Yes ☐ No If no, preferred language: _____

Please ☑ *ALL* that apply: ☐ Visually Impaired ☐ Hearing Impaired
☐ Language Barrier ☐ Veteran ☐ Smoker ☐ Homeless ☐ Migrant Farm Worker

Please ☑ your Religion: ☐ Christian ☐ Agnostic ☐ Atheist ☐ Buddhist ☐ Jewish
☐ Hindu ☐ Islamic ☐ Pentecostal ☐ Scientologist ☐ Other

Please ☑ Tax Filing Status: ☐ Return Not Filed ☐ Single ☐ Married ☐ Head of Household
If you ☑ Head of Household, please indicate if the Head of Household is a: ☐ Male ☐ Female

Please ☑ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated
☐ Divorced ☐ Life Partner ☐ Other

Please ☑ Student Status: ☐ Full-time Student ☐ Part-time Student

CONTACT PREFERENCES:

☑ to indicate the method of contacting preferred: ☐ Home ( ) _____ ☐ Day/Work ( ) _____
☐ Cell/Alternate ( ) _____ ☐ E-mail _____

Emergency contact name and numbers			

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No If YES, at which hospital is it filed? _____

PRIMARY HEALTH SOLUTIONS, INC (PHS)

Acknowledgement Of Receipt Of Privacy Practices

We are required to give each patient a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. By signing this form you acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most efficient way possible.

If you have an answering machine at home, may we leave a message?	Yes	No
May we leave a message at your work for you to call our office?	Yes	No
May we e-mail you?	Yes	No
Is there a person at your house that we may leave a message with?	Yes	No

List below any person/persons authorized by you to discuss/receive your medical information:

_____

Name/address/phone/relationship

_____

Name/address/phone/relationship

Employer (Name, Address, Phone Number

Do you live in public housing? ☐ Yes ☐ No

Household Members

Name	Date of Birth	Relationship	Income	Hr/Wk/Bi-Wk/Yr

Because we receive some funds to help us offer care to the uninsured, we are asked to keep track of the income of all our patients. We also offer a sliding fee scale for people with no insurance, and we need this information to calculate their discount. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

Income Before Taxes	Hr/Wk/Bi-Wk/Yr	Other Income	Documented
$ per			
Family Size			

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the attending provider/physician. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Primary Health Solutions. I authorize the release of information to my insurance carrier and authorize payment directly to Primary Health Solutions. I have read and fully understand the above.

Signature: _____ Date: _____

( ) Patient ( ) Parent ( ) Guardian

Print Name and Address: _____

Witness: _____ Date: _____

Primary HEALTH SOLUTIONS
YOUR FAMILY. YOUR COMMUNITY. YOUR HEALTH.

Hamilton School-Based Health Center Student Information

OneSight

HAMILTON CITY SCHOOL DISTRICT

In order to provide health services for your child we need the following information:

Patient's Name: _____

Parent/Guardian Name: _____Parent/Guardian's Date of Birth: _____

Relationship to Child: _____Parent/Guardian's Social Security No.: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____

Regular Primary Care Provider or Clinic: _____

Address _____Phone #: _____

Date of last complete yearly physical examination (head to toe): _____

Regular Dentist/Clinic: _____ Phone #: _____

Date of last routine dental check-up: _____

Date of last complete yearly optical examination: _____

Do you want a copy of the physical exam to go to your clinic or doctor? Yes _____ No_____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Parent/Guardian Signature_____ Date of Signature_____

(Please continue to the next page)

SCHOOL HEALTH HISTORY FORM

Please complete, sign and return to the school office as soon as possible.

PATIENT NAME_____

1. Is your child allergic to any medications?

No_____ Yes_____ If yes, please list: _____

2. Any severe food allergies? Please list _____

Any other allergies? Please list _____

3. Does your child or any family member have or had any of these problems? (Please Check)

	Child	Family		Child	Family		Child	Family
Asthma or wheezing	____	____	Fainting with exercise	____	____	Nightmares	____	____
Allergies/hay fever	____	____	Frequent Headaches	____	____	Rheumatic Fever	____	____
ADHD / ADD	____	____	Frequent Sore Throats	____	____	Seizure Disorder	____	____
Anemia / blood problems	____	____	Frequent Stomach Aches	____	____	Sickle Cell problems	____	____
Anaphylactic reaction	____	____	High Cholesterol	____	____	Sinus Trouble	____	____
Abnormal spinal curvature	____	____	Heart Murmur	____	____	Sleep Problems	____	____
Alcohol / Drug Abuse	____	____	Hearing Loss/Problems	____	____	Snoring	____	____
Acne	____	____	Heart Disease	____	____	Speech Problems	____	____
Behavior problems	____	____	High Blood Pressure	____	____	Stomach Ulcers	____	____
Boys: testicle not in sac	____	____	HIV / Aids	____	____	Suicide	____	____
Bowel Movement in pants	____	____	Hives	____	____	Stroke	____	____
Bleeding Disorders	____	____	Hyperactivity	____	____	Toothache/Dental problems	____	____
Broken bones	____	____	Joint problems	____	____	Tuberculosis	____	____
Cancer – type	____	____	Kidney Disease/Problems	____	____	Underweight	____	____
Chicken pox	____	____	Lead Poisoning	____	____	Urinary Tract Infections	____	____
Diarrhea/ constipation	____	____	Learning Problems	____	____	Eye lid Twitching	____	____
Chronic ear infections	____	____	Leukemia	____	____	Eye Burning	____	____
Concussion	____	____	Lumps in groin/breast	____	____	Double Vision	____	____
Depression	____	____	Mental Illness	____	____	Dry Eye	____	____
Diabetes	____	____	Migraines	____	____	Eye Strain	____	____
Dizziness / Light headed	____	____	Muscle Problems	____	____	Itchy Eyes	____	____
Eczema / skin infections	____	____	Nervous twitches/Tics	____	____	Watery Eyes	____	____
Vaginal Discharge	____	____	Nose Bleed	____	____	Light Sensitivity	____	____

PATIENT NAME_____

Medical History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child CURRENTLY take any medications? YES NO _____

Has your child taken any medication(s) in the past? YES NO _____

Has your child ever been pregnant? YES NO How many living children has your child given birth to?_____

Has your child ever been in the hospital overnight? YES NO _____

Has the child had any surgery(ies)? YES NO _____

Has your child had any head injury(ies)? YES NO _____

Does your child have any developmental delays? YES NO _____

Dental History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child have any dental pain? YES NO _____

Does your child brush their teeth? YES NO _____

Does your child floss? YES NO _____

Has your child received fluoride treatments? YES NO _____

Has anyone explained the importance of primary teeth to your child? YES NO

Student's History

Please circle yes or no below, and explain any yes answers on the line provided:

Has anyone had a heart attack before age 50? YES NO _____

Is there a gun in the home? YES NO _____

Does anyone at the child's home smoke? YES NO _____

Has your child been a victim of abuse? YES NO _____

Has your child seen someone be abused? YES NO _____

Is your child been a victim of bullying? YES NO _____

What Activities/Hobbies does your student have:

_____

_____

_____

PATIENT NAME_____

School History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child have any learning problems? YES NO _____

Is your child in a special class (IEP)? YES NO _____

Has your child repeated a grade? YES NO _____

Does your child get into trouble often at school? YES NO _____

What are your child's grades? _____ Is this a change? Yes _____No_____

Vision History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child currently wear glasses currently? YES NO Broken/Lost

If yes: Full-Time Distance Only Reading _____

Does your child wear contact lenses currently? YES NO

If yes: Brand _____ *Solution*: Optifree Renu Peroxide _____

Wearing: Remove Nightly Sleep In Daily Replacement _____

Replacement: Monthly 2 Weeks Daily _____

Has your child or any family members been diagnosed with/or had:

HISTORY	**EYE**	**STUDENT**	**FAMILY MEMBER (LIST RELATIONSHIP):**
Glaucoma	R L	_____	_____
Cataracts	R L	_____	_____
Eye Injury	R L	_____	_____
Eye Pain	R L	_____	_____
Lazy Eye	R L	_____	_____
Retinal Detachment	R L	_____	_____
Macular Degeneration	R L	_____	_____
Diabetes		_____	_____

Has your student had any of the following eye surgeries?

LASIK	YES	NO	_____
Cataract	YES	NO	_____
Eye Muscle	YES	NO	_____
Eye Lid	YES	NO	_____

Signature of Parent/Guardian _____ Date_____

Thank you for your time used in completing your child health history and consent form.

Consent for Nitrous Oxide Sedation

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Primary Health Solutions dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections ("Novocain"). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be "asleep" and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

Patient Name

Signature (Parent/Guardian) Phone Number Date

THE FOLLOWING PAGES

ARE FOR YOU TO REVIEW

AND KEEP FOR YOUR

RECORDS

Primary HEALTH SOLUTIONS
YOUR FAMILY. YOUR COMMUNITY. YOUR HEALTH.

Program Description
Hamilton School-Based Health Center

HAMILTON CITY SCHOOL DISTRICT

OneSight

Welcome to Primary Health Solutions' Hamilton School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child without having to take time away from work and minimize the time that your child is out of the learning environment.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, dental care, eye exams, and all associated health care concerns. Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, attempts will be made to contact you as necessary. .
- **The School-Based Health Center does not take the place of your primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with that PCP and a summary of your child's visit at the SBHC will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and can become your child's PCP. If your child is already a patient of any Primary Health Solutions locations, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call **(513) 454-1111**.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Primary Health Solutions sliding fee scale. This information will be kept strictly confidential.
- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at Primary Health Solutions. If your insurance does not cover Primary Health Solutions, you will be responsible for the bill at the appropriate discounted fee based on your household income.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call **(513) 454-1111**. You can also contact the Butler County Job and Family Services Department at (513) 887-5600.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's PCP.
- Primary Health Solutions, the School-Based Health Center and/or the Hamilton City Schools' nurses will share medical information, including immunization records, with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, School-Based Health Center or Primary Health Solutions may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Primary Health Solutions' Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Primary Health Solutions reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Primary Health Solutions at 210 South Second Street, Floor 2, Hamilton, OH, 45011.

With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or Primary Health Solutions may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or Primary Health Solutions restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in Hamilton Public Schools. You **may revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Primary Health Solutions at **(513) 454-1111** or contact your school nurse.