HealthPoint
Your Community Health Center

SCHOOL-BASED HEALTH CENTER PATIENT REGISTRATION

Section A for student to complete

Last Name	First Name	Middle Name	
Social Security Number	Birth Date		Gender ☐ M ☐ F
Mailing Address	City	State	Zip
Home Address (if different)	City	State	Zip

Which county do you live in?
☐ King ☐ Pierce ☐ Snohomish ☐ Other

What language do you usually speak?

Phone Numbers (Check if Primary Phone)
☐ Home Phone_____
☐ Cell Phone_____
☐ Alternate Phone Number(s): _____
☐ Emergency Contact Name/Phone : _____

Are you Hispanic? ☐ Yes ☐ No

Do you use an interpreter? ☐ Yes ☐ No

What is your race or biological family background? (Check all that apply)
☐ White ☐ Black
☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander

Section B for parent or guardian to complete if student is under 18 years of age.

Parent/Guardian's Last Name	Parent/Guardian's First Name		
Mailing Address			Phone
Relationship to Patient ☐ Parent ☐ Guardian	Social Security Number	Gender ☐ M ☐ F	Birth Date

Section C for student to complete.

Marital status
☐ Single ☐ Married ☐ Divorced
☐ Life Partner ☐ Widowed ☐ Legally Separated

Are you the spouse, partner, or child of someone who has served/or is serving in the US Military? ☐ Yes ☐ No

Which of the following best describes your household?
☐ Married with no dependent children
☐ Single ☐ Two-parent household
☐ Single female with dependent children living with you
☐ Single male with dependent children living with you

Are you disabled? ☐ Yes ☐ No

What is your household's monthly income?_____

Total number of people in your household (people who live in the same house and depend on the same income) _____

Total number of children under 18 in your household _____

Are you homeless or in a temporary shelter?
☐ Not homeless ☐ Doubling Up ☐ Transitional
☐ Street ☐ Shelter ☐ Public Housing
☐ Other:_____

Are you a migrant or seasonal farm worker? ☐ Not a farm worker
☐ Seasonal farm worker ☐ Migrant farm worker

Student status ☐ Full Time ☐ Part Time ☐ Not a student
Student ID_____ **Grade**_____
School_____

Do you have medical insurance? ☐ Yes ☐ No

Section D for student to complete if age 18 or older. For parent or guardian to complete if student is under 18 years of age.

PRIVACY PRACTICE NOTICE, RELEASE AND CONSENT SIGNATURE

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/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 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 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 Medical/Dental Director. The assignment and release authorizes HealthPoint 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.
Please initial in these two boxes:

→ *Initials* **Notice of Privacy Practices**: I have received **HealthPoint's Notice of Privacy Practices** that describes how my health information may be used and disclosed And how I can access my information.

→ *Initials* **I give my consent** to HealthPoint and its photographer to photograph or film me and/or my children for marketing purposes to show the benefits of school-based health centers. I also give HealthPoint the right to use and publish the photographs/videos of me and/or my children.

Signature Relationship to Student Date

[PATIENT LABEL HERE]

HEALTHPOINT STAFF ONLY
Scan Date: _____ Initials: _____

HealthPoint School-Based Health Center
Consent for Health Services

HealthPoint School-Based Health Centers (SBHC), located on campuses owned by the Highline School District, must have a signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access such treatment without parent/guardian consent. If the student is enrolled in school but is not enrolled in the Tyee or Evergreen Campus Health Center, he/she can continue to receive School Nurse services. I hereby request and authorize that:

Print Students Name:_____ _____ _____
First Middle Last Date of Birth

may receive health care services from and deemed necessary by HealthPoint staff. These services may include, but are not limited to routine medical care, mental health counseling, naturopathy, sports physicals, well-teen (preventive) care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, and dental screening. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the HealthPoint staff. This authorization does not allow services to be rendered without the student's consent, unless she/he is unable to consent.

Additionally, consent is given:

For SBHC to share necessary information with Highline School District, including exchange of information between the SBHC behavioral health consultant, nurse practitioner or physician assistant and the Highline School District staff, for the purpose of providing the best care for the above named student.

For the SBHC providers to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.).

For the student named above to receive medical services at one of the HealthPoint medical centers listed below:

HealthPoint Auburn: (253) 735-0166	HealthPoint Federal Way: (253) 874-7634	HealthPoint SeaTac: (206) 277-7200
HealthPoint Bothell: (425) 486-0658	HealthPoint Redmond: (425)882-1697	HealthPoint Kent: (253) 852-2866
Health Point Renton: (425) 226-5536	HealthPoint Tukwila (206) 439-3289	HealthPointEvergreen: (206)-835-2615

The student may choose to withdraw the consent at any time.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist. For example:

Permission is given by the patient through a signed release of information.
The patient indicates risk of imminent harm to self or others.
The patient has a life-threatening health problem and is under 18 years old.
There is reason to suspect abuse or neglect.
Certain communicable diseases must be reported to public health authorities.

Student Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Name/Relationship of Legally Responsible Guardian (Print):_____

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MPORTANT ADDITIONAL INFORMATION

HealthPoint School-Based Health Centers encourage each student to involve his/her parents or guardians in health care decisions whenever possible. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Also, starting at age 13, youth may independently receive drug and alcohol cessation services and mental health counseling without parent/ guardian consent. Starting at age 14, youth may independently receive testing and/or treatment for HIV and STI's. Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted infections. Consent from students age 13 and over, and parent/guardian consent for students age 12 and under is legally required for release of information about alcohol and drug or mental health counseling.