Community Health Center, Inc.
SUMMER MEDICAL ENROLLMENT

I give permission for myself/my child to obtain **MEDICAL SERVICES** *All insurances will be billed at time of visit. No out of pocket fees or copays associated with services	YES	NO
I certify that the health information provided is accurate to the best of my knowledge and that incorrect information can be dangerous to the student/patient's health	YES	NO
I agree that messages can be left for me on the telephone number provided in the student/parent section of this form	YES	NO
I have received a copy of CHC's Rights and Responsibilities Policy	YES	NO
RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to Community Health Center, Inc. for services provided	YES	NO
CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES I consent to the use or disclosure of my protected health information by Community Health Center, Inc. (CHC) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information use or disclosed to CHC may include HIV/AIDS related information, psychiatric/mental health information, drug/alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how CHC will use and disclose my information can be found in CHC's Notice of Privacy Practices. I understand my consent is effective for as long as CHC maintains my protected health information.	YES	NO
AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION: I hereby authorize Community Health Center, Inc. (CHC) to exchange health and education records with my child's school district and primary care provider for the purpose of providing care and treatment to my child, if applicable.	YES	NO

Parent/Legal Guardian Signature or Student signature if over 18 years old: ______________________________

Print Name of Individual/Parent/Legal Guardian : ______________________________ **Date:** ____________

By signing above, I understand and acknowledge that I have read and understand this consent and I have received CHC's Notice of Privacy Practices currently in effect. I also understand that this authorization is valid until I revoke this authorization. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my or my child's ability to obtain health care. I agree that a copy of this authorization is as valid as the original.

Patient Information

Full Legal Name: ______________________________ Date of Birth: ____________
First Middle Last

Address: ______________________________

Sex: ____________ **Social Security Number:** ______________ Ethnicity (Please circle): Hispanic Non-Hispanic

Race: (Please circle one) Unknown American Indian Pacific Island Alaskan Native Black Asian White Other

Patient's primary language: ________ Family Size:______ Family Income: ______ Does the patient qualify for free/reduced lunch?: ______

School patient attends: ______________ Grade: __________ Teacher: ______________

Primary Insurance: ______________ ID number: ______________ Group Number: __________

Insurance Address: PO Box ____________ Insurance Phone Number: ______________ (info on back of card)

Policy Holder Name: ______________ Policy Holder DOB: __________ Policy Holder SSN: __________

Physician's Name: ______________________ Physician's Phone Number: ______________

Parent/Guardian Information

Name: ______________________ DOB: ________ Relationship: ______________

Address (if different from above): ______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address of Parent/Guardian: ______________________________

Allergies to Medication/Food	Yes	No	If yes:			Any Surgeries?	Yes	No
Take Medication Daily?	Yes	No	If yes:			Any hospitalizations?	Yes	No
Anemia	Yes	No	Endocrine/Gland Disease	Yes	No	Birth defect /Heart issue	Yes	No
Asthma	Yes	No	Headaches/Migraines	Yes	No	Scoliosis	Yes	No
Autism	Yes	No	Hepatitis	Yes	No	Seizures	Yes	No
Bladder or Kidney Infections	Yes	No	Learning/Developmental Issues	Yes	No	Severe Acne	Yes	No
Cancer	Yes	No	Mononucleosis	Yes	No	Sleep Issues	Yes	No
Chicken Pox	Yes	No	Overweight/Obesity	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	Pneumonia	Yes	No	Tuberculosis	Yes	No
Eating Issues	Yes	No	Rheumatic fever/heart disease	Yes	No	Ulcer/Digestive Problem	Yes	No