E. A. HAWSE HEALTH CENTER
SCHOOL BASED HEALTH REGISTRATION FORM

- ☐ **YES!** I give consent for my child to participate in services offered at the School Based Wellness Center. I understand billable visits will only be provided with permission prior to the time of services.
- ☐ **No!** I do not give consent for my child to participate in services offered at the School Based Wellness Center.

School:	**Grade:**	**Teacher:**

PATIENT INFORMATION

Student's last name: First: Middle:	Birth Date:	Sex: Male☐ Female☐	Social Security No:

Street address:	P.O. Box:	City:	State:	Zip Code:

Parent/Guardian Name:	Best daytime phone number: Home phone number: Cell phone number:	Parent Date of Birth Parent Social Security #

Street address:	P.O. Box:	City:	State:	Zip Code:

Race: White☐ Black☐ American Indian or Alaskan Native☐ Asian or Pacific Islander☐ Other☐ ____________________
Ethnic Origin: Caucasian or White☐ Hispanic or Latino☐ Hispanic Latino/Black☐ Not of Hispanic or Latino☐ Declined☐ Unknown☐
Language: English☐ Spanish☐ Other☐ ______________________________
Sexual Orientation: Straight☐ Lesbian or gay☐ Other: ______________________
Gender Identity: Male☐ Female☐ Transgendered Male/Female☐ Transgendered Female/Male☐ Declined☐ Other ____________________

Does your child have any medical problems? If yes, please explain: ________________________________

Is your child allergic to medications: ☐ Yes ☐ No If yes, please list: ________________________________

Is your child taking any medications on a regular basis? ☐ Yes ☐ No If yes, please list the medications and dose: ________________

____

Have there been any major changes in your child's health since the last school year? (For example, a newly diagnosed illness, a surgery, a hospital stay, etc.) ________________________________

____

Who is your child's doctor? ________________________ **Pharmacy of choice** ____________________

IF WE ARE UNABLE TO CONTACT YOU, WHO SHOULD WE CALL?

Name: ______________________ Phone# ______________ Relationship to child ______________

Name: ______________________ Phone# ______________ Relationship to child ______________

Patient ☐will enroll in Sliding Fee Program. **OR** Patient ☐will not enroll in Sliding Fee Program and has declined coverage.

INSURANCE INFORMATION

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD WITH THIS FORM

Is this patient covered by insurance? ☐Yes ☐No	Name of Primary Insurance:

Subscriber's Name:	Subscribers Social Security #:	Birth Date:	Group No:	ID No:	Co-Payment: $

Subscribers Address:	Home phone:

Occupation:	Employer:	Employer Address:	Employer Phone No:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other ____________________

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

Patient's relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to E. A. Hawse Health Center. I understand that I am financially responsible for any unpaid balance. I also authorize E. A. Hawse Health Center to release any information required to process my insurance claim. I authorize E. A. Hawse Health Center's Medical, Dental and Behavioral Health staff to consult together and to perform needed treatments and/or diagnostic tests for necessary care including Medical, Dental or Behavioral Health services.

______________________________ ______________
Patient/Guardian Signature *Date*
Email Address: ______________________________

(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801
HAWSEHEALTH.COM

Acknowledgements

I acknowledge that I have received and understand E. A. Hawse Health Center's *Payment and Scheduling Policies*. I further understand that E. A. Hawse Health Center may update these policies any time and that I may receive an updated copy by submitting a request in writing.

I acknowledge that I have received and understand E. A. Hawse Health Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that E. A. Hawse Health Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of E. A. Hawse Health Center's *Notice of Privacy Practices* by submitting a request in writing.

I give permission for E. A. Hawse Health Center to release medical information to the following:

NAME	RELATIONSHIP	PHONE NUMBER

If your child needs to be seen at school or at one of our offices, please list anyone who has permission to bring your child for medical or behavioral health treatment:

NAME	RELATIONSHIP	PHONE NUMBER

May we leave medical information such as test results on your answering machine? ☐ Yes ☐ No

Printed Patient Name ______________________ Date of Birth ______________________

Patient Signature ______________________ Date ______________________

If completed by patient's personal representative, please print and sign below.

Printed Patient Personal Representative Name ______________________ Relationship to Patient ______________________

Patient Personal Representative Signature ______________________ Date ______________________

☐ Please keep this signature on file should I have to pay for services using my credit card

For E. A. Hawse Health Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative. E. A. Hawse Health Center made a good faith effort to obtain patient's written acknowledgement of the Payment and Scheduling Policies and Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign ☐ Other
☐ Patient or patient's personal representative unable to sign

Printed Employee Name/Signature ______________________ Date ______________________

Cd6:\HIPAAAcknowledgementBH.Medical.Dental\blt\3.11.19