MOBILE HEALTH CLINIC – REGISTRATION FORM

North Olympic Healthcare NETWORK

Student Information: *Complete entire Form – Incomplete Forms may result in delay or denial of service

Legal Name _____

Preferred Name _____

School _____ Grade_____

Date of Birth _____ Sex ___M ___F

Student's Identifying Gender _____

Patient Contact #: Can we call/**text** you for scheduling and appointment reminders? Circle one (Y / N)

Cell # _____ Home #_____

Address _____

City _____ State _____ Zip _____

Student's Race / Ethnicity (check all that apply):

_____ American Indian / Alaskan Native _____ Asian

_____ Black / African American _____ Hispanic or Latino

_____ Native Hawaiian or Other Pacific Islander _____ White

_____ Other: _____

Parent / Guardian Information:

Name _____

Date of Birth _____ Relation _____

Phone #: Cell _____ Home _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian SS# _____

Student's Emergency Contact:

Name _____

Relation to Student _____

Phone #: Cell _____ Home _____

Student lives with: (Check all that apply)

_____ Mother _____ Father _____ Legal Guardian

_____ Grandparent(s) _____ Foster Parent(s)

_____ Emancipated Minor _____ Other

Student's Doctor: _____

REQUEST TO DISCLOSE PHI-Personal Health Information (Scheduling info only): To better coordinate your care, NOHN requests your consent to release limited Behavioral and Medical health information only about scheduling to PASD staff:

I, _____ (DOB) _____ authorize and give permission for my protected health information to be shared with my school to coordinate my care but limited to only information necessary to facilitate scheduling and communications about appointments. This release may include attendance office staff, counselors, nurses, teachers, and PASD Navigators. I understand that I may amend or revoke this at any time in writing and that the changes or revocation will take effect immediately upon a written request.

_____ _____

Signature of Patient or Authorizing Representative **Date**

Insurance Information:

Does student have health insurance? ___ Yes ___ No

Insurance Plan Name _____

Policy Number _____

Group Number _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber's Relation to Patient _____

Additional Information:

Services Sought: ___ Medical ___ Behavioral Health

Fees and Billing: No one will be denied service due to inability to pay, but the following information is required so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information, we will bill you at full fee for service.

Sliding Fee Program: If the student does not have insurance and does not qualify for Apple Health, we can provide sliding fees for certain services. ***Please complete below.***

Gross Monthly Household Income $_____

Number of Family Members in Your Household _____

MOBILE HEALTH CLINIC – CONSENT FORM

North Olympic Healthcare NETWORK

I give permission to North Olympic Healthcare Network (NOHN) to perform such medical and therapeutic procedures as may be professionally necessary or advisable to my (or my child's) health screening, diagnosis, and treatment.

I understand that a patient record will exist for each student and that I am responsible for medical expenses that may occur. (NOHN will bill your insurance company. Anything not paid by the insurance company will be billed to you.)

In the case of medical health services, the NOHN MUST have a signed Consent Form from a parent or legal guardian before health services are provided to youth.

I understand that the following types of services may be offered through the NOHN Mobile Health Clinic:

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Laboratory tests
- Referral for health care services that cannot be provided on the mobile unit
- Mental health services
- Health education, counseling, and/or wellness promotion
- Immunizations
- Reproductive health services, like counseling, education, exams, and referrals

According to law, MINORS may provide their **own** consent for substance abuse treatment and mental health care services at the age of 13 or older. MINORS may provide their **own** consent for reproductive health care at any age. If necessary, NOHN will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

When a student consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- If a student shows signs of risk of suicidal behavior.
- If a student has a life-threatening health problem and is under 18 years old.
- If the student gives us permission through a signed release of information.
- If student plans to do serious bodily harm to someone else.
- If there is reason to suspect abuse or neglect. This may include any sexual contact with a minor (people under 18 years old) by a person older than 18 **or** where this is a three or more year difference in ages.

Please Note: The student's consent is LEGALLY required for release of information about the following: pregnancy, sexually transmitted disease (including HIV/AIDS testing), substance abuse treatment, and/or mental health counseling.

Student's Signature	PRINT Student's Name	Date
Parent / Guardian Signature	PRINT Parent / Guardian Name	Date

Relationship to Student: _____

*Complete entire Form – Incomplete Form may result in delay or denial of service

Do you need your services to be confidential? *Circle (Y / N) *If yes, a PASD or NOHN Navigator will contact you. You can choose to start or stop confidential services at any time.*

If you are a student and want to learn more Confidential Care, including what options are available for you, please reach out to your PASD Family Navigator, Nurse, Teacher, or Counselor.