Gaston Family Health Services

Student Enrollment

Student INFORMATION	ACCOUNT #:		Date:
Students Legal Name (Last, First, Middle)	Preferred Name	Race:	Ethnicity:
Social Security Number / Date of Birth	Sex: Male Female		Home Phone Number
The child lives with: ☐ Mother ☐ Father ☐ Grandparent(s) ☐ Guardian(s): _____			
School:	Grade:	Homeroom Teacher:	
Preferred Notification Method: ☐ Postal Mail ☐ Phone ☐ Email ☐ Web Message			

Mother / Guardian(s) Name:			Father / Guardian(s) Name:		
Date of Birth	Sex	SSN	Date of Birth	Sex	SSN
Address			Address		
City	State / Zip		City	State / Zip	
Home Phone	Cell Phone		Home Phone	Cell Phone	
Work Phone	E-Mail Address:		Work Phone	E-Mail Address:	
Employer Name			Employer Name		

INSURANCE INFORMATION PRIMARY			SECONDARY / SUPPLEMENTAL		
Name of Plan			Name of Plan		
Claims Address (Street Address/P.O. Box)			Claims Address (Street Address/P.O. Box)		
City	State / Zip		City	State / Zip	
Phone Number			Phone Number		
Patient Policy Number	Group Number		Patient Policy Number	Group Number	
Subscriber Name (if different from patient): (Last, First, MI			Subscriber Name (if different from patient): (L, F, MI)		
Subscriber Sex : ☐ M ☐ F	Subscriber Policy #:		Subscriber Sex: ☐ M ☐ F	Subscriber Policy #:	

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Primary			Secondary		
Guarantor Employer Name			Guarantor Employer Name		
Effective Date		Expiration Date	Effective Date		Expiration Date
Copay Amount $	Relationship to child		Copay Amount $	Relationship to child	
Plan Type: ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay			Plan Type: ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay		
Person Responsible for Payment of Bill: ☐ Mother ☐ Father ☐ Guardian or Other _____					
☐ If your child has no insurance you may be eligible for discount based on sliding scale, additional information and paperwork may be necessary to complete					
EMERGENCY CONTACT: (Other than Mother or Father)					
Name (Last, First, Middle)					Relationship
Home Phone Number	Work Phone Number		Cell Phone Number		

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

No enrolled student will be denied services because of the inability to pay

I guarantee payment to GFHS and its affiliates for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of behavioral benefits, which would otherwise be payable to me, to GFHS Inc for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION

I voluntarily consent to behavioral healthcare treatment from the GFHS behavioral health providers and staff of GFHS. I am aware that the delivery of behavioral health services/treatment are an exact science. No guarantees have been made to me regarding the results of therapeutic services and counseling interventions by my providers. I understand that GFHS employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between GFHS providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I certify that I have read and understand this form.

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CONFIDENTIAL SERVICES: I understand that North Carolina General Statutes Section 90 – 21.5 protects a minor's right to receive services relating to sexually transmitted diseases, pregnancy, drug abuse and emotional disturbances without parental consent. I understand that according to NC General Statutes 90 – 21.4 medical providers are not required to notify me about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. I further understand that GFHS and all its affiliates will make every effort to encourage my child to discuss problems and services with me.

For services not designated as confidential, I understand that I will be kept informed of my child's SHC visits and treatments. When an outside referral or services (including prescription medications) is indicated, I will be informed as well as my child's PCP. In the event my child requires urgent medical care and I cannot be reached, I request that my child be provided care to stabilize his/her condition. (*Children age 11 and over may be allowed to authorize their own urgent care with the understanding that I will be contacted as soon as possible. Children age 10 and under may require a parent or other adult, chosen by the parent, to accompany the child to the visit. Names of authorized adults who may accompany my child have been shared with the student health center.)*

90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

Signature of Student's Authorized Representative _____

Date: _____/_____/_____

Office Use Only:

_____ _____

Witness Signature **Date / Time**

General Comment Section

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter Refused

Name /Number of Person/services chosen/used

Gaston Family Health Services

Parent Questionnaire

Student Name:	**ACCOUNT #:**	**Date:** _____

Student Health History

Daily Medication:	**Reason for taking:**

Chronic Medical/Behavioral Health Conditions for your child (Check all that apply)

☐ Diabetes	☐ Attention Deficit Disorder (ADD/ADHD)
☐ Kidney Disease	☐ Autism Spectrum
☐ Seizures	☐ Depression
☐ Migraines	☐ Anxiety
☐ Asthma	☐ Eating Disorder
☐ Heart Problems	☐ Self-Harm behaviors
☐ Dental Concerns	☐ Substance Use/Abuse
☐ Vision Concerns	☐ Tobacco Use/Abuse
☐ Other health related concerns/allergies	☐ Learning Disabilities
_____	☐ Other behavioral health related concerns:
	_____

Has there been any changes to your child's health in the past year?
☐ **Yes** ☐ **No** **If yes, explain:**

Has your child been hospitalized overnight for medial or mental health reasons?
☐ **Yes** ☐ **No** **If yes, explain:**

Has your child ever had serious surgeries or injuries (note specifically head trauma)?
☐ **Yes** ☐ **No** **If yes, explain:**

Household Information

Please name the people living in your household and their ages: (Example: Father (40) Mother (40) Sister (10)

Is there a firearm in the household?
☐ **Yes** ☐ **No** **If yes, is it safely stored? (locked safe):**

Does anyone in your household smoke?

Family Mental Health History: (please list immediate family members diagnosis/treatment)

Parent/Guardian Concerns: Please review topics and write out any additional areas:

☐ **Mental health**	☐ **Sexual Behaviors**
☐ **Weight/eating**	☐ **School Performance**
☐ **Relationships with family member**	☐ **Smoking/Vaping**
☐ **Choice of friends**	☐ **Drug Use**
☐ **Sleep**	☐ **Self Harm**

Staff will keep all answers private, please return questionnaire in sealed envelope provided.

Gaston Family Health Services

Authorization for Release of Protected Information – ROI

I, _____ _____
Student's Legal Representative | Relationship to Student

Authorize:

Gaston Family Health Services | 704-874-9005
Agency or Person authorized to disclose the information | Agency's Telephone Number

409 South Oakland Street | Gastonia | NC | 28052
Agency's Street Address | City | State | Zip

To exchange with or disclose to: (bi-directional information exchange)

Newton Conover City Schools | 828-464-3191
Agency or Person to whom the requested use or disclosure will be made | Agency's Telephone Number

605 N. Ashe Avenue | Newton | NC | 28658
Agency's Street Address | City | State | Zip

Regarding:

_____ | ___/___/___ | _____
Student's Name | Student's Date of Birth | Student's Telephone Number

_____ | _____ | _____ | _____
Student's Street Address | City | State | Zip

the following protected information:

- ☐ Mental Health Records:
  - o appointment attendance
  - o Diagnoses
  - o Screening/diagnostic tools
  - o Care team members
  - o Treatment/care plan
- ☐ Barriers to care/SDOH (i.e. transportation, housing concerns, etc.)
- ☐ Behavioral Health Visit Notes
- ☐ Physical Health Records
- ☐ Billing Information
- ☐ School/Academic Records
  - o Attendance records
  - o Academic grades
  - o EOG/EOC testing scores
  - o Other academic achievement test records
  - o Psychoeducational test records
  - o Special Education Records
  - o Discipline records
  - o Behavioral conduct details
- ☐ HIV diagnosis/treatment
- ☐ Substance use/treatment

The purpose of this disclosure is to provide proof of level of engagement in care and an understanding of barriers and treatment concerns in order to efficiently coordinate care and services.
Describe purpose of the requested disclosure

Gaston Family Health Services

Authorization for Release of Protected Information – ROI

This authorization shall be in effect for 12 months from the initial date of request unless otherwise noted below.

STUDENT'S RIGHTS AND AUTHORIZED SIGNATURE:

- I have the right to revoke this authorization at any time by completing a revocation form and returning to a GFHS staff member.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that the students treatment/academics or payment or eligibility for benefits will not be conditioned on signing.
- I understand that released information may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or HIV).

Signature of Student's Authorized Representative **Date**

Employee Name **Employee Title**

Employee Signature **Date**