GATEWAY SCHOOL-BASED HEALTH CENTER
Hilltown Community Health Centers
12 Littleville Road
Huntington, MA 01050
(413)667-0142

CONSENT TO TREAT AND AUTHORIZATION TO DISCLOSE INFORMATION ENROLLMENT FORM

PATIENT INFORMATATION

Last Name _____ First Name _____ MI _____

Phone Number (_____) _____ Social Security Number _____

DOB _____ Age _____ Gender: □Female □Male □Transgender Check one: □Student: Grade _____ □Staff

Street Address _____ City _____ State _____ Zip Code _____

Mailing Address (If different) _____ City _____ State _____ Zip Code _____

Mother's Name/Legal Guardian _____ Daytime Phone (_____) _____

Father's Name/Legal Guardian _____ Daytime Phone (_____) _____

Emergency Contact Name _____ Phone Number (_____) _____

RACE/ETHNICITY INFORMATION

What is your race/ethnicity?
□American Indian/Alaska Native
□Asian
□Black/Not Hispanic □Hispanic/Spanish/Latino
□Native Hawaiian Islander □White/Not Hispanic
□More Than One (1) Race □Other/Unknown

In what language do you prefer to discuss health-related concerns?
□English
□Indian (including Hindu)
□Other
□Russian
□Spanish

In what language do you prefer to read health-related materials?
□English
□Indian (including Hindu)
□Other
□ Russian
□Spanish

INSURANCE INFORMATION

Insurance company _____ Subscriber Name _____ DOB _____

Address _____ Phone Number (_____) _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number _____ Name of Employer _____

MEDICAL INFORMATION

Primary Care Physician _____ Phone Number (_____) _____

Address _____ City _____ State _____ Zip Code _____

Pharmacy _____ Phone Number (_____) _____

Address _____ City _____ State _____ Zip Code _____

Is your child taking any medications (including fluoride/daily vitamins)? _____

Does your child have any chronic illness or health conditions? (Example diabetes/ asthma) _____

Does your child have any allergies? _____

Your Opinion matters!!

☆ DOES YOUR CHILD HAVE AN EYE DOCTOR AND RECEIVE ROUTINE EXAMS? YES OR NO

WOULD YOU USE EYECARE SERVICES AT SCHOOL IF THEY WERE AVAILABLE? YES OR NO

I consent and give permission for (me/my child or ward) to be treated by and to receive medical or mental health services (with or without my presence) from the Gateway School-Based Health Center (SBHC). I understand that such medical or mental health services may be provided by or at the direction of a nurse practitioner, physician, or mental health professional.

If the patient is a student I consent to and authorize the disclosure of patient information and records by the SBHC to the Gateway Regional School (School) and its agents and for the exchange of patient information and records between the SBHC and the School and its agents, which such patient information and records may include but is not limited to medical or mental health information or records that may relate to HIV, AIDS, venereal disease, psychiatric or mental health, alcohol or drug abuse, or communications with psychologists, psychotherapists, social workers, allied mental health providers, domestic violence counselors, or sexual assault counselors.

I also consent to and authorize the disclosure of patient information and records by SBHC to the patient's primary care provider and other providers for treatment purposes and to insurers and other third party payors for billing and payment purposes. I understand that my insurer may be billed for any services provided by SBHC to the patient and that my insurer may receive patient information and records as needed for billing and payment purpose. I may be responsible for any charges incurred by the patient that are not covered by my insurer including but not limited to deductibles and copays. I understand that the SBHC will disclose patient information and records as may be required by relevant law. This consent and authorization shall remain in effect as long as the patient is a student in the school, unless I rescind this consent and authorization in writing.

I understand that, under Massachusetts law, there are certain circumstances where minors have the right to consent, on their own, to confidential diagnosis and treatment. These circumstances can include, for example, treatment of sexually transmitted diseases, pregnancy, substance abuse, mental health, and medical emergencies, or where the minor is married, a parent, or self-supporting. For such treatment authorized by minors only, the parent/guardian is not responsible for payment. In all these cases, the minor is encouraged to share information with the parent/guardian when appropriate. Please call the SBHC with any questions.

Privacy:

The School-Based Health Center complies with all federal and state privacy regulations (HIPAA). We will use your protected health information only for treatment and billing purposes, and we will obtain your permission before releasing your medical records except as may be requires by law. To read HIPAA information and the notice of Patient Rights Acknowledgement it is located on the Hilltown Community Health Centers website at www.hchcweb.org or a copy can be mailed to you upon request by calling (413)-667-0142.

Parent/Guardian Signature OR

Patient (Adult/Emancipated Minor) _____ Date: _____

****Please enclose a copy of insurance card if possible.