



# PATHS

Live Life. Be Healthy.

### Services Offered by PATHS School-Based Health At Your School via Mobile Unit

- Dental Exams
- Sports Physicals
- Medical Care
- Immunizations
- Prescriptions
- Vision Care
- Labs

NAME: \_\_\_\_\_

Gender Identity  Male  Female  Transgender/Male to Female  Transgender/Female to Male

Student Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_

Genderqueer, neither exclusively male or female  Choose Not to disclose

Student School: \_\_\_\_\_

### Mailing Address

Lives with  Father  Mother  Both  Other: \_\_\_\_\_

Do you live in public housing?  Yes  No  Homeless

Are you a Student?  Yes  No Are you a veteran?  Yes  No

How do you prefer to be contacted?  Mail  Phone  Email  In person

Race (check all that apply):  Black/African American  White  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander  Japanese  DECLINE

Ethnicity:  Hispanic  Non-Hispanic  DECLINED to specify Preferred Language:  English  Spanish  Other: \_\_\_\_\_ Interpreter Needed:  Yes  No

Accessibility Needs:  Hearing Impaired  Vision Impaired

## PARENTS/LEGAL GUARDIANS

Parent of Legal Guardian Name

Phone# (Home or Cell)

Phone # (Work)

Email Address

Parent of Legal Guardian Name

Phone# (Home or Cell)

Phone # (Work)

Email Address

## RESPONSIBLE PARTY (REQUIRED)

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this person also a patient enrolled in other PATHS services?  Yes  No

## INSURANCE INFORMATION

Please check all that apply and send in a copy of the insurance card(s)

HEALTH INSURANCE (Private insurance, Medicaid, ID Number/Policy Number, etc.)  NO HEALTH INSURANCE

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthday: \_\_\_\_\_

PRIMARY Insurance Company

ID/Policy Number

Group Number

Do you have prescription coverage?  Yes  No

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthday: \_\_\_\_\_

SECONDARY Insurance Company

ID/Policy Number

Group Number

Do you have prescription coverage?  Yes  No

## HEALTH INFORMATION

Doctor's Name \_\_\_\_\_ Current Medications \_\_\_\_\_

Please place an **X** for the following services you would **NOT** like for your child to have during the current school year in the School-Based Health Center:

Medical Care  Sports Physicals  Immunizations  Labs  Prescriptions  Dental Exams  Vision Care

## EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Phone: Home \_\_\_\_\_ Phone: Cell \_\_\_\_\_ Phone: Work \_\_\_\_\_

I authorize PATHS School-Based Health to leave messages related to my care on my answering machine/voicemail  Yes  No

## NOTICE OF PRIVACY PRACTICE/PARENTAL CONSENT

**PATHS School-Based Health Notice of Privacy Practices are posted in the School-Based Health Center.** Also, I may obtain a Notice of Privacy Practice by contacting the School-Based Health Center at (434) 791-0216. The Notice of Privacy Practice describes the types of uses and disclosures of your child's protective health information that might occur for their treatment, payment of their bills, or in the performance of PATHS School-Based Health Center operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your child's protected health information. I understand that PATHS School-Based Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the PATHS School-Based Health Center and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

**I, the parent/guardian of said student, give consent for him/her to receive health services.** I understand those services may include nursing care, medical treatment, and referral for counseling; and that all healthcare information is confidential. I certify that I have been informed of the policies and procedures related to how PATHS School-Based Health Center, a division of Piedmont Access to Health Services, Inc., may use and /or disclose your child's personal health information.

**By signing this consent form:**

- (1) I am authorizing my child to receive services in my absence;
- (2) I am agreeing to accept the risks of medical procedures, medication(s), testing (including HIV), and other treatments;
- (3) I am agreeing to abide by the PATHS procedures and patient responsibilities set out in this form;
- (4) I am granting PATHS permission to bill my child's insurance for services provided.

I acknowledge that I have read this form or had this form read and explained to me, that I understand it and agree to its content. I agree to be truthful in providing information.

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**Signature of Parent/Guardian**

**Date**