School Year 2016-2017

Dear Parent,

Open Door Health Services will be offering physical and dental health services for students at your child's school through their mobile school-based health center.

Why School-Based Health Centers?

Access to Health Care for All Children
School-based health centers provide health care to all children who have parental consent, no matter insurance coverage or ability to pay (often at no cost or low cost).

Regular Preventive Care
When health care is far away, expensive, or hard to get, children are less likely to receive regular preventive care. School-based health centers offer care where the children are – in schools.

Keeping Children in School
School-based health centers help keep children in school and ready to learn. Acute and chronic health problems can be treated immediately. This allows students to return to class as soon as possible.

Strong Parent and School Support
When parents allow their child to be seen at a school-based health center, they know they will not have to miss work to take their child for care. Their child will receive quick attention from health providers trained at working with youth. School staff and teachers are very supportive of school-based health centers. The health centers allow them to focus on their role of teaching students who are healthy and ready to learn.

Schedule
The mobile unit will be at the schools on the following schedule:

Or you can find the schedule posted on our web site at www.opendoorhs.org

Thank you for your time!

Sincerely,

Bryan Ayars, CEO

Open Door Health Services
On-The-Go Mobile Unit
CONSENT FOR TREATMENT
School Year: 2016-2017
School Attending: _____

Fill out both sides and return

_____

(Please Print) Student's Last name First Name Middle Name DOB

I give permission for my child, listed above, to receive health services from Open Door Health Services On-The-Go mobile unit without me being present. I understand that the On-The-Go unit may not be able to take care of all the health needs my child may have. My consent will allow my child to receive health services (including medical, dental and behavioral health) while he/she is a student at this school. If I change my mind, I must write a letter to Open Door Health Services stating my intentions. It will also be my responsibility to notify Open Door Health Services staff about changes in guardianship, address and phone numbers of my child.

If my child is not already under the care of a regular health care provider, I can ask ODHS staff to assist me in choosing a regular provider for my child.

I acknowledge my responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to ODHS.

If you want to be contacted by phone after your child's visit to the mobile unit please list your contact number. If no number is listed, a note will be sent home with child.
Contact Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The signature below acknowledges that I have been provided Open Door Health Services' (ODHS) Notice of Privacy Practices.

- It tells me how ODHS will use my health information for the purposes of my treatment, payment for my treatment, and ODHS's health care operations.
- The notice also explains in more detail how ODHS may use and share my health information for other than treatment, payment, and health care operations.
- ODHS will also use and share my health information as required/permitted by law.
- I have also been told Open Door may use my contact information to remind me of appointments and/or needed health services unless I request a confidential communication option.
- I understand Open Door Health Services may communicate with my child's primary medical provider, school nurse, school social worker or insurance company as needed to provide coordination of care.
- I understand that this consent if good for the school year listed above and if my child does not use these services the consent and associated paper work will be destroyed.
- I gave Open Door Health Services permission to set up an appointment to apply for health care coverage for which I am eligible. I authorized Open Door Health Services to store and use my contact information from the patient information form for this purpose.

Signature: _____ Date: _____
(Patient or Legally Authorized Representative)
Relationship of Legally Authorized Representative to Patient: _____

On-The-Go Mobile Unit

HEALTH HISTORY - IDENTIFICATION-INSURANCE INFORMATION FORM

School Year: 2016-2017

Student Name: _____ Date of Birth: _____ Gender Male Female

Address: _____ City: _____ Zip: _____

School: _____ Grade: _____ Teacher: _____

Pharmacy name and address: _____

Medical History:

Name of child's regular medical provider:	**Name of child's regular dental provider:**	**List any allergies to food, medication or insects:**
List any medications child is taking:	**List all medical conditions:** **Has your child had Chickenpox?**	**Past surgeries:**
Please list any other medical information you feel necessary for us to know to treat your child:		

Health Insurance:

Health Insurance: ☐ Yes ☐ No – See sliding fee information below **

Please fill out the following information in order for us to file your insurance. If we are not able to collect from your insurance, you will be responsible for any services that are rendered.

Primary Insurance	**Secondary Insurance**	**Responsible Party** **(**Person Responsible for bill)
Policy Number:	Policy Number:	Name:/Relationship to patient:
Group Number:	Group Number:	Address:
Policy Holder (Name on card):	Policy Holder (Name on card):	City/State/Zip:
Date of Birth	Date of Birth	SS#/Date of Birth:
Relationship to Patient:	Relationship to Patient:	Phone: (home/cell/work)

Patient Identification:

ODHS is a Federally Qualified Health Center that receives government funding. The funding for your health center is based on information you provide and is necessary for us to better serve you, our patient. Please complete the following information for reporting purposes.

Marital status: Single Married Divorced	Number of people in household: _____	Military Service: No Active Veteran
Ethnicity: Hispanic/Latino Yes No	Annual Income: _____	Migrant Worker: Yes No
Race: White/Caucasian Black/African American Asian Multi-Race American Indian/Alaskan Other:	Primary Language at home: English Spanish Do you need an Interpreter: Yes No	Homeless: Yes No

Contact Information:

Child lives with: Parent Grandparents Other Relative Guardian Other: _____
Name/ Home Phone/ Cell Phone/ Work phone
Name/ Home Phone/ Cell Phone/ Work phone

** The sliding fee scale is available to assist those patients that have no Insurance by offering our services at a discounted rate. Patients are required to apply for the sliding fee scale on a yearly basis. In order to qualify for the sliding fee scale at ODHS, patients and their families must have a combined income that falls within the U.S. Federal Poverty Guidelines. The determination of qualification is based on the number of members in the household and the monthly household income. Upon request, a sliding fee scale application will be provided and should be returned with the information above within 30 days of the mobile unit visit.