The Family Health Centers of Georgia, Inc.

ATTENTION PARENTS

Your children now have access to comprehensive healthcare, education, and support services through our **School-Based Health Centers** or our **Mobile Medical & Dental Unit**. The Family Health Centers of Georgia, Inc. (FHCGA) has joined in partnership with schools and communities to provide comprehensive healthcare services to students. Your child can receive healthcare for illnesses, injuries, physicals, etc. during school hours.

Please complete **ALL** of the attached forms. Please return your completed package, including a copy of your child's insurance card and a legible color copy of your valid photo ID, to the designated school representative.

IMPORTANT: Please keep the attached "Notice of Privacy Practices" brochure for your records.

The Family Health Centers of Georgia, Inc. | 868 York Avenue, SW | Atlanta, GA 30310 | 404.752.1400

The Family Health Centers of Georgia, Inc.

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STUDENT REGISTRATION FORM

Information for Parent/Guardian
Information for Student

Is student a FHCGA patient? [ ] Yes [ ] No

Date:_____

PATIENT INFORMATION

Student's Name:_____
(first) (middle initial) (last)

Parent/Guardian's Name:_____
(first) (middle initial) (last)

Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Social Security #:_____

Contact Numbers: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Student's Date of Birth:_____ Age:_____

Student's Social Security #:_____ Sex:_____ Race:_____

INSURANCE INFORMATION (Please present current insurance card to a FHCGA representative.)

[ ] Medicaid [ ] AMERIGROUP [ ] PeachState [ ] WellCare [ ] private insurance [ ] uninsured

If private insurance, please indicate insurance company's name:_____

Member Name (as listed on insurance card):_____ Policy #:_____

PERSON RESPONSIBLE FOR PAYMENT INFORMATION

THIS SECTION MUST BE COMPLETED, EVEN IF YOU ARE USING MEDICAID, OR PRIVATE INSURANCE.

Relationship to patient: [ ] Self [ ] Parent/Guardian [ ] Spouse [ ] Other (specify)_____

[ ] Check here if information is the same as above. Only complete section below if any information is different.

Name:_____
(first) (middle initial) (last)

Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

Contact Numbers: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

STUDENT AUTHORIZATION FOR TREATMENT

The Family Health Centers of Georgia, Inc.

Student's Name:_____ Date of Birth:_____

The Family Health Centers of Georgia, Inc. (FHCGA) is required to obtain consent to treat and disclose all material risks and alternative medical treatments. I understand that it is not possible to list every material risk for every Procedure or Medical treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the Procedure or Medical treatments.

Medical Treatment and/or Procedures may include, but are not limited to the following:

1. **Needle Sticks**, such as injections (shots). The material risks associated with this type of procedure include, but are not limited to, nerve damage, infection, or bruising. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective), or refusal of medical treatment.
2. **Physical tests, assessments and medical treatments**, such as vital signs, internal body examinations, wound cleaning, wound dressing, range of motion checks, and other similar procedures. There are no known major risks associated with these procedures. Medical Treatment may consist of treatment for illnesses (i.e., strep throat, ear infections, pink eye, scrapes, strains, cuts, well child checks, etc.).
3. **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The Material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, or allergic reaction. Apart from varying the method of administration and/or refusal of medical treatment, no practical alternatives exist.
4. **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The Material risks associated with these type of Procedures include, but are not limited to, infection, bleeding, or nerve damage. Apart form long-term observation and/or refusal of medical treatment, no practical alternatives exist.

BY SIGNING THIS FORM:

- I consent to FHCGA healthcare professionals performing medical treatment and procedures as they deem reasonably necessary in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed in general terms of the nature and purpose of the medical treatment and procedures, the material risks of procedures, and practical alternatives to the procedures.
- If I have any questions or concerns regarding these Medical treatments or Procedures, I will ask my physician to provide me with additional information.
- In order to insure medication safety and lack of drug interactions, I grant the FHCGA and its staff the right to access my electronic pharmacy and prescription information.
- I acknowledge that I have read and understand the above information and I give permission for myself or my child's care as described.

Signature of Patient (or authorized person to sign):_____

Printed Name of Patient:_____ Date Signed:_____

Reason Patient Unable to Sign (if applicable):_____ Relationship:_____

Acknowledgment of Receipt of Notices of Privacy Practices (HIPAA): I acknowledge that I have received the Notice of Privacy Practices

_____ _____

Signature of Patient or Legal Representative Date

Authorization for Medical treatment by Physician Assistant: I understand that the Family Health Centers of Georgia, Inc. and its affiliates utilizes certified Mid-Level Providers (i.e.; Physician Assistants (PA), etc.) to treat patients for the level of care for which they have been approved by the Georgia State Board of Medical Examiners. Your signature on this form conveys that you are in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

_____ _____

Signature of Patient or Legal Representative Date

The Family Health Centers of Georgia, Inc.

STUDENT HEALTH QUESTIONNAIRE

Today's Date:_____

1. Student's Name:_____ _____ _____
Last First Middle Initial

2. Student's Date of Birth:_____ Age:_____ Grade:_____

3. School's Name:_____ Homeroom Teacher's Name:_____

4. School Year:_____ Student ID #:_____

The information you provide is **STRICTLY CONFIDENTIAL**. Its purpose is to help us give your students better healthcare. We ask that you fill out the form completely. **You may skip any question you do not wish to answer.**

FAMILY INFORMATION

Parent/Legal Guardian's Name: _____ _____ _____
Last First Middle Initial

How are you related to the above named student?_____

1. With whom does the student live? (check all that apply)

[ ] both natural parents [ ] stepmother [ ] alone
[ ] mother [ ] stepfather [ ] brother(s)/ages:_____
[ ] father [ ] guardian [ ] sister(s)/ages:_____
[ ] adoptive parents [ ] other (explain)_____

2. If student is under 18, does anyone else provide care? [ ] Yes [ ] No
If yes, who?_____

3. Does student have any known health problems? [ ] Yes [ ] No
If yes, what?_____

4. Where does student go when he/she is sick?_____

5. Where does student go for dental care?_____

6. Does student have any known allergies to any medications? [ ] Yes [ ] No
If yes, what?_____ Type of reaction:_____

7. Is student taking any medications (over the counter, prescription, homeopathic or herbs)? [ ] Yes [ ] No
If yes, what?_____

8. Has student ever been hospitalized or had surgery? [ ] Yes [ ] No
If yes, when?_____ Where?_____ Why?_____

9. Does student have any health concerns? [ ] Yes [ ] No
If yes, what?_____

10. Does student and/or parent/legal guardian work outside the home? [ ] Yes [ ] No
If yes, what type of work do they do?
Student:_____ Mother:_____
Father:_____ Legal Guardian:_____

FAMILY'S MEDICAL HISTORY

11. Does the student's mother, father, siblings or grandparents have any of the following?

		If yes, who?			If yes, who?
asthma	[ ] Yes [ ] No	_____	high blood pressure	[ ] Yes [ ] No	_____
cancer	[ ] Yes [ ] No	_____	learning problems	[ ] Yes [ ] No	_____
diabetes	[ ] Yes [ ] No	_____	lung problems	[ ] Yes [ ] No	_____
drinking problems	[ ] Yes [ ] No	_____	mental illness	[ ] Yes [ ] No	_____
drug problems	[ ] Yes [ ] No	_____	nerve problems	[ ] Yes [ ] No	_____
heart problems	[ ] Yes [ ] No	_____	other_____	[ ] Yes [ ] No	_____

FAMILY'S HEALTH HABITS

12. If applicable, how often does student use a seatbelt or car seat? (please circle answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

13. Does student ride a bicycle, skateboard or roller blade? [ ] Yes [ ] No

If yes, how often does he/she use a helmet? (please circle answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

14. Does student need information about safety (strangers, weapons, fire, etc.)? [ ] Yes [ ] No

15. On average, how many hours of sleep does student get each night? _____ hours

16. Do you feel like the student lives in a safe place? [ ] Yes [ ] No

17. Have there been any major changes in your family in the last year? (check all that apply)

[ ] moving [ ] violence or serious accident [ ] death of family member [ ]birth
[ ] loss of job/income [ ] physical, emotional, or sexual abuse [ ] other_____

18. Is there a gun in your home? [ ] Yes [ ] No

If yes, is it locked? [ ] Yes [ ] No

19. Does anyone in your household smoke? [ ] Yes [ ] No

20. Do you currently smoke? [ ] Yes [ ] No

If yes, how may cigarettes/cigars do you smoke per day? _____

STUDENT'S SCHOOL HISTORY

21. Did student attend preschool? [ ] Yes [ ] No

22. Do you have any concerns about student's school performance? [ ] Yes [ ] No

If yes, what?_____

23. Do you have any concerns about student's relationships with teachers? [ ] Yes [ ] No

24. Do you have any concerns about student's relationships with other students? [ ] Yes [ ] No

25. Do you have any concerns about student's relationships with siblings or other family members? [ ] Yes [ ] No

26. If over 4 years old, does student have a best friend? [ ] Yes [ ] No

27. Does student participate in sports, have hobbies, special interests, or talents?

If yes, what?_____ How long?_____ How often?_____
_____ _____ _____

STUDENT'S MEDICAL HISTORY

Student's Name:_____ _____ _____
Last First Middle Initial

Student's Date of Birth:_____ (Month/Date/Year)

Student's Primary Care Physician/Doctor's Name:_____

Date of Student's last visit:_____

→ ILLNESS HISTORY (Check below if student has/had any of the following conditions) (Check all that apply)

[ ] AIDS/HIV
[ ] allergic to drugs
[ ] allergies
[ ] anemia
[ ] asthma
[ ] blood disorders
[ ] broken bones
[ ] cancer
[ ] chicken pox age:_____
[ ] constipation/diarrhea
[ ] diabetes
[ ] ear infections
[ ] ear problems
[ ] eye glasses
[ ] eye problems
[ ] fainting spells/knocked out
[ ] frequent colds
[ ] frequent sore throat
[ ] headaches
[ ] hearing aid
[ ] heart murmur
[ ] heart problems
[ ] hemophilia
[ ] hepatitis
[ ] high blood pressure
[ ] injuries (major)
[ ] kidney/urinary tract problems
[ ] lung problems
[ ] meningitis
[ ] menstruation problems
[ ] menstruation started Age:_____
[ ] musculo-skeletal problems
[ ] obese/overweight
[ ] physical/sexual abuse
[ ] premature birth weight_____
[ ] problems walking
[ ] respiratory problems
[ ] rheumatic fever
[ ] seizures/epilepsy
[ ] serious acne
[ ] serious digestive problems
[ ] sickle cell disease
[ ] sickle cell trait
[ ] skin rashes
[ ] speech problems
[ ] stomach ulcers
[ ] thyroid problems
[ ] tuberculosis
[ ] underweight
[ ] other_____
_____

Explain any illness(es) checked above:_____

_____

_____

→ BEHAVIOR HISTORY (Check below if student has/had any of the following conditions) (Check all that apply)

[ ] alcohol
[ ] bedwetting
[ ] behavior problems
[ ] depression
[ ] discipline problems
[ ] drugs_____
[ ] eating problems
[ ] inhalants
[ ] learning disabilities
[ ] mental problems
[ ] nightmares
[ ] overactive/hyperactive
[ ] shy
[ ] sleeping problems
[ ] slow development
[ ] smoker
[ ] thumb sucking
[ ] other_____

Explain any behavioral items checked above:_____

_____

_____

→ DENTAL HISTORY

28. When was student's last dental visit?_____

29. How often are student's teeth brushed?

[ ] Occasionally [ ] Once a Day [ ] Twice a Day [ ] Other_____

30. Has student had a toothache or tooth pulled in the last month? [ ] Yes [ ] No

clearinghouses that request your information. Participation in information exchange serves also lets us see their information about you.

OTHER USES OR DISCLOSURES:

Business Associates: There are some services provided in our organization through contacts with business associates. Examples-include physician services in emergency situations, radiology, and certain laboratory tests.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: We may disclose relevant health information to a family member, friend, or other person you identify regarding your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Fundraising/Marketing: We may contact you as part of a fundraising or marketing effort. If you do not want us to contact you for these efforts, you must notify the Medical Records Department.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Appointment Reminders/Treatment Alternatives: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

If you have any questions about this notice, please contact:

Corporate Office
The Family Health Centers of Georgia, Inc.
(formerly West End Medical Centers, Inc.)
868 York Avenue, SW
Atlanta, Georgia 30310
404.752.1400
fhcga.org

NOPP (effective09232013)-08222014

The Family Health Centers of Georgia, Inc.

Affordable access to healthcare excellence

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your *medical history*, symptoms, examination and test results, diagnoses, treatment, *care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.*

Understanding what is in your record and how your Health Information is used helps you to;

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of The Family Health Centers of Georgia, Inc. the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522:
  You may request restrictions on how your health information is used for treatment, payment or health care operations, or to certain family members or others who are involved in your care. We may deny your request with one exception; *we must approve your request to not disclose information to a health plan if you have paid out-of-pocket in full for all expenses for a particular item or service.* If we agree to a restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment or is required by law to make a disclosure.

- Right to obtain a paper copy of this Notice:
  You may request an additional paper copy of this Notice at any time from any patient registration area.

- Right to inspect and copy your health record as provided for in 45 CFR 164.524:
  You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Medical Record Department; we may charge you a copying fee plus postage. *If your record is in electronic format, you have the right to request your copy in electronic format.*

- Right to Request Amendment:
  You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Medical Records Department. We may deny your request, if so; you will be notified of our decision in writing.

- Right to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
  You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations). To request an accounting of disclosures, you must send a written request to the Medical Records Department. Your request must state a time period that may not be longer than six-years and may not include dates before April 14, 2003.

- Right to request communications of your health information by alternative means or at alternative locations:
  You may request that we communicate with you in a certain way, in a certain location. You must make your request in writing to the patient registration area or to the medical record department and explain how or where you wish to be contacted.

- *Right to revoke or restrict your authorization to use or disclose health information except to the extent that action has already been taken or as required by law.*

- *Right to be notified in the event of a breach of your health information.*

- *Right to opt out of communications for fundraising purposes*

OUR RESPONSIBILITIES:

The Family Health Centers of Georgia, Inc. is required by law to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- notify you in the event of a breach of your information
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations and to *restrict information to certain entities as outlined in this notice.*

Should our Notice of Information practices change or revisions are made, the Notice will be made readily available upon request on or after the effective date of the revisions to existing patients. We will not use or disclose your health information without your authorization, except as described in this Notice.

YOUR AUTHORIZATION IS REQUIRED TO RELEASE THE FOLLOWING INFORMATION:

- Psychotherapy notes
- Marketing purposes (including subsidized treatment communications)
- Disclosures that constitute a sale of PHI
- Release of your health information to any outside agency (except as required by law)
- Other uses and disclosures not described in this Notice will be made only with your prior authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If have questions and would like additional information or If you believe your privacy rights have been violated, you can file a complaint with Risk Management at (404) 752-1408 or with the Secretary of Health and Human Services. *There will be no retaliation for filing a complaint.*

EXAMPLES OF DISCLOSURES FOR TREATMENT PAYMENT AND HEALTH OPERATIONS

- *We will use your health information for treatment:*
  For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you.

- *We will use your health information for payment:*
  For example: We may disclose health information about you to other qualified parties for their payment purposes.

- *We will use your information for regular healthcare operations:*
  For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of healthcare and service we provide.

- *Health Information Exchange:*
  We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care