REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____ Social Security Number_____
First Middle Last

Date of Birth_____ Sex at Birth (male or female)_____

Address_____
Street City, State, Zip

Email Address_____

Home Phone Number_____

Cell Phone Number_____

Can we leave a message? ❑ Yes ❑ No

Last Grade Completed_____

Public Housing ❑Yes ❑ No

Email Address_____

Preferred Method of Contact
❑Electronic portal (via secure messaging)
❑voicemail ❑email ❑text/SMS

Ethnicity ❑Hispanic ❑Non-Hispanic ❑Decline to answer

Race ❑Black/African American ❑Caucasian (White)
❑American Indian/Alaskan Native ❑Asian
❑Native American Pacific Islander ❑Native Hawaiian
❑Multiple Races ❑Decline to answer

Gender Identity (*Check off one box only please)*
❑Male
❑Female
❑Transgender Male (Female-to-Male)
❑Transgender Female (Male to Female)
❑Other
❑Decline to answer

Sexual Orientation (*Check off one box only please)*
❑Straight
❑Gay
❑Lesbian
❑Bi-sexual
❑Other
❑I don't know
❑Decline to answer

Employer_____

Veteran ❑Yes ❑No

Country of Origin_____

Marital Status ❑Single ❑Married ❑Separated ❑Divorced ❑Widow

Language Preference_____

Name of Pharmacy_____

FOR CHILDREN

Mother/Guardian Name_____ Phone Number_____

Father/Guardian Name_____ Phone Number_____

Children live with ❑Mother ❑Father ❑Guardian

Mother's Maiden Name_____

The persons listed above may sign consent for treatment, on behalf of my child

_____ _____ _____
Patient/Guardian Signature Signature of Legal Representative Date

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

***The persons listed above can NOT sign consent for treatment, on behalf of my child.**

IN CASE OF EMERGENCY

Emergency Contact Name_____ Phone Number_____

Relationship to patient ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

FINANCIAL/INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of person responsible for bill_____ Date of Birth_____

Social Security Number_____ Phone Number_____

Address_____

Street City, State, Zip

Household Income $_____
❑Yr. ❑Mo. ❑Wk. ❑Bi-wkly

Number of Dependents
spouse/children under 18

Primary Insurance_____ Policy Holder Name_____ Policy Number_____

Secondary Insurance_____ Policy Holder Name_____ Policy Number_____

Patient's relationship to Insured ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

Complete Below for Private Insurance Only

_____

Employer Name Employer Phone Number Group #

GENERAL CONSENT FOR TREATMENT AND PRIVACY NOTICE

The above information is true to the best of my knowledge. I hereby give Optimus Health Care and its medical providers my consent for any necessary medical evaluation and treatment.

I acknowledge that I have reviewed the Optimus Health Care

□ Notice of privacy practice
□ "No Show" Appointments policy and,
□ Patient Bill of Rights in the language of my understanding

I also understand that I may request another copy at any time. I authorize Optimus Health Care, Inc. or insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance due, regardless of insurance or third party accommodations.

_____ _____ _____

Patient/Guardian Signature Signature of Legal Representative Date

OPTIMUS HEALTH CARE

Patient Bill of Rights

All Optimus Health Care, Inc. patients have the rights and responsibilities outlined below:

1. The patient has the right to receive complete information and confidentiality regarding their medical condition and treatment plan.
2. The patient has the right to complete information on the services and off-hour coverage system of Optimus Health Care, Inc.
3. The patient has the right to complete information regarding research projects that might include them and the right to refuse to participate in such projects.
4. The patient has the right to their complete medical records upon request.
5. The patient has the right to complete information regarding fees, charges, and reimbursement policies of Optimus Health Care, Inc.
6. The patient has the right to have treatment provided with consideration, respect, and privacy.
7. The patient has the right to be assessed for pain management and to be treated and/or referred to a specialist.
8. The patient has the right to a second opinion from a physician of their choosing.
9. The patient has the right to file a grievance requesting a resolution of their concern. The patient has the right to request changes in processes as it affects the services provided to them. The patient has the right to communicate directly with The Joint Commission (www.jointcommission.org), by which Optimus Health Care, Inc. is accredited.

Appointment Policy

To ensure access to appointments for all patients, Optimus Health Care, Inc. has the following policy regarding a patient who frequently misses their appointments:

- If you are unable to keep a scheduled appointment or call the office with less than 24 hours' notice to cancel or reschedule an appointment, each such appointment will be considered a "No Show."
- If you miss three (3) appointments within a six (6) month period, you will be considered a frequent "No Show" for future appointments.
- Patients who frequently "No Show" for appointments will be allowed to schedule future appointments only during designated health center hours.
- This policy applies to medical, dental, pediatrics, behavioral health, and OB/GYN patients.
- Optimus will continue to provide you with care during designated health center hours.

- You have the right to appeal Optimus Health Care, Inc.'s determination that you frequently "No Show" to appointments. The health center staff can guide you in beginning the appeal process, and a decision will be made within 30 days.

About our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practice provides information regarding:

- Our obligations under the law concerning your personal health information
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this Notice
- The person to contact for further information about our privacy practices

FOR SCHOOL-BASED HEALTH CENTER REGISTRATION

School Name_____ Grade _____ Room Number _____

Student Mobile number _____

MEDICAL HISTORY/ALLERGIES		
Does the patient have any medical conditions?	☐ Yes	☐ No
Does the patient take any medications? (Including inhalers)	☐ Yes	☐ No
Does the patient have any allergies to food, medications, or local anesthetics?	☐ Yes	☐ No
Does the patient carry an EPI-PEN at school in case of an allergic reaction?	☐ Yes	☐ No
Has the patient had any serious injuries?	☐ Yes	☐ No
Does the patient have a birth or heart defect?	☐ Yes	☐ No
Does the patient have a history of heart problems or surgery?	☐ Yes	☐ No
Has the patient had any surgery in the past?	☐ Yes	☐ No
Has the patient had any shunts placed or have an indwelling catheter?	☐ Yes	☐ No
Does the patient smoke or chew tobacco?	☐ Yes	☐ No
Has the patient ever been hospitalized overnight? (medical or mental health)	☐ Yes	☐ No
Does the patient have any behavioral issues you are concerned about? (Ex: concentrating, completing tasks, fits of anger, skipping classes/school, not accepting responsibility for their actions)	☐ Yes	☐ No
Does the patient struggle with any social relationship issues? (Ex: not getting along with friends/peers or family, being able to keep neat/clean/caring for self)	☐ Yes	☐ No
Does the patient have any trouble with being motivated, worrying more than they should, feeling good about themselves?	☐ Yes	☐ No
If answered yes to any of the above, please comment below.		
Please list any concerns you have regarding your child's Physical or Mental Health.		

DENTAL HISTORY		
Does the patient have any medical conditions?	☐ Yes	☐ No
Does the patient take any medications? (Including inhalers)	☐ Yes	☐ No
Does the patient have any allergies to food, medications, or local anesthetics?	☐ Yes	☐ No
Does the patient carry an EPI-PEN at school in case of an allergic reaction?	☐ Yes	☐ No
If answered yes to any of the above, please comment below.		

FAMILY HISTORY				
Select One		Illness	Relative	Explain
☐ Yes	☐ No	Diabetes, Endocrine Disorder (Thyroid)		
☐ Yes	☐ No	Cancer		
☐ Yes	☐ No	Heart Problem, Stroke		
☐ Yes	☐ No	High Blood Pressure		
☐ Yes	☐ No	Blood Disorder including Anemia		
☐ Yes	☐ No	Clotting Disorders		
☐ Yes	☐ No	Respiratory Problems, including Asthma		
☐ Yes	☐ No	Mental Illness (i.e., Depression)		
☐ Yes	☐ No	Alcohol/Drug Problems		
☐ Yes	☐ No	Infections (TB/HIV/AIDS)		
☐ Yes	☐ No	Death Under the age of 50		
☐ Yes	☐ No	Other		

SBHC PARENT/GUARDIAN CONSENT & SIGNATURE

I, the parent/guardian of the student listed above, give consent for my child to receive the services checked above at the school-based health center.

- ☐ I understand that this consent will be valid for two years or until I provide the school-based health center staff-written notice of my revocation.
- ☐ I understand that my consent permits the school-based health center staff to communicate my child's health information on an as-needed basis with the school nurse and your child's regular doctor (if applicable) with the understanding that this information will continue to be treated as confidential under applicable law.
- ☐ The School-Based Center staff will cooperate and communicate with the Board of Education staff whenever student behavior or health may result in a risk of harm to the student or others within the school setting.
- ☐ Special restrictions apply for disclosures concerning certain health information such as HIV-related information or records regarding substance abuse or behavioral health treatment.
    - ○ Generally, we will disclose such information only with an authorization that explicitly permits the disclosure of such information or as otherwise permitted or required by law.
- ☐ By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the student's health appears to be endangered. Students receiving care with the School-Based Center will be encouraged to involve their parents/guardians in counseling and medical care decisions.
- ☐ I consent to the health center releasing information regarding treatment to third-party payors for billing purposes.
- ☐ I understand that no student will be denied access to health care services due to the inability to pay. When available, the School-Based center will bill insurance or Medicaid.
- ☐ I understand that the School-Based Center staff will maintain confidentiality between my child and the health center staff for certain services by following the applicable law. By law, some information requires your child's written consent before disclosure to anyone, including parents/guardians. The health center staff will encourage every student to involve their parent/guardian in health care decisions.

I am the legal guardian of the child named above. I understand that the legal guardian must sign a new consent if guardianship changes. By providing an alternative contact, I also understand that medical information regarding the child named above will be shared between the School-Based Center clinician/staff and the alternative contact if the School-Based Center cannot reach me.

Parent/Guardian Consent & Signature		
I give my child permission to obtain ON-SITE MEDICAL SERVICES.	☐ Yes	☐ No
I give my child permission to obtain ON-SITE DENTAL/MOBILE DENTAL SERVICES	☐ Yes	☐ No
I give my child permission to obtain ON-SITE BEHAVORAL HEALTH SERVICES.	☐ Yes	☐ No

Signature		**Date**	
Print Name		**Relationship to Patient**	

TELEMEDICINE CONSENT SCHOOL-BASED HEALTH CENTER

The Optimus Health Care, Inc. ("Optimus") School-Based Health Center in your child's school is now offering telemedicine services. Telemedicine services are conducted by two-way video conferencing for treating certain medical conditions such as: asthma, allergies, bronchitis, and other minor infections and providing behavioral health services, including individual and group therapy. Telemedicine visits are a convenient and easy way for your child to receive health care while at home or in a private room at school, if available. As with providing in-person care for your child in the School-Based Health Center, Optimus must obtain your consent to provide telemedicine services to your child.

I understand and agree that:

1. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that protects the privacy of health information also applies to telemedicine services.
2. I may at any time revoke my consent to treat my child using telemedicine services by sending a letter to the School-Based Health Center office at my child's school. I further understand that such revocation will not affect my child's ability to receive in-person care at the School-Based Health Center.
3. The benefits of telemedicine include improved access to medical or behavioral health care and a more efficient evaluation and management of medical or behavioral health needs.
4. The risks related to telemedicine services include, but not limited to, the transmission of my child's health information intercepted and accessed by unauthorized persons, despite Optimus' use of a HIPAA compliant telemedicine platform and other security protocols that are in place and the transmission could be disrupted or distorted by technical failures resulting in the inability to continue the visit.
5. The alternative to telemedicine is in-person encounters and such encounters are available to my child
6. The Optimus clinician may terminate a telemedicine visit if they determine that my child's medical or behavioral health condition cannot be appropriately addressed virtually, or that information transmitted is not of sufficient quality to permit appropriate medical decision making. Under such circumstances, the clinician will schedule my child for the next available in-person appointment for care or call 911 for emergencies.
7. Optimus may have to terminate telemedicine services if the laws or executive orders permitting the delivery of care in this manner are revoked.
8. If my child is home during a telemedicine appointment, I will provide my child a private space behind closed doors and, if possible, provide headphones for privacy.
9. My insurance or my child's Medicaid coverage will be billed for telemedicine services provided. Children without insurance coverage will not be denied telemedicine care.
10. I can speak with the Optimus School-Based Health Center clinician should I have any questions about telemedicine or at any time after signing this form.

I have read and understand the information provided in this telemedicine consent form and consent to my child receiving telemedicine services as appropriate.

I give my child permission to obtain TELEMEDICINE SERVICES		☐ Yes	☐ No
Signature		**Date**	
Print Name		**Relationship to Patient**	