HealthPoint Family Care | Locations in Bellevue, Covington & Florence Extended Hours & Walk-ins

Enroll Today for the 2017/2018 School Year Full Service Medical and Dental Office at Ludlow Independent Schools

HealthPoint Family Care is pleased to partner with Ludlow Independent Schools to provide onsite healthcare to your children. Medical and Dental services are located at Ludlow High School and open to all district students.

The HealthPoint School Based Health Centers (SBHC) are a safe and easily accessible place on school grounds where students can go for comprehensive preventive and primary health care services. The SBHC is staffed by a Nurse Practitioner and a School Nurse. The SBHC does not intend to replace your child's primary care provider but these services will help to address the gaps families may have accessing necessary healthcare.

Enrollment in the school based health services is optional. You can enroll at any time during the school year by calling your school nurse. Please complete the attached paperwork and return to your school if you want to enroll today.

Before receiving services the following paperwork must be completed and turned in to the school. Please note that these forms are required to be updated annually. See the grey arrows ⇒ for required signatures. Any incomplete forms will be returned to you.

- **Dental enrollment form – see ⇒**
- **School Based Health Center Patient Profile – see ⇒**
- **Health History form – see ⇒**
- **Consent to Treat a Minor/HIPAA/Acknowledgement of Receipt on Notice of Privacy Practice. If you choose not to sign the Acknowledgement Of Receipt On Notice of Privacy Practice a HealthPoint Representative will contact you to see if you have questions – see ⇒ for 2 required signatures.**

Health Center Fees for Medical Visits:

- All **Uninsured patients** will be billed **$20** for their visit.
- All **Commercial patients** will be billed **$55** for their visit unless they have an Anthem, United Healthcare, Tricare, Aetna or Humana plan that does not have a required PCP or with a HealthPoint Provider as the PCP and then HealthPoint will bill the plan copay. There is an additional charge for immunizations for commercially insured patients.
- **Medicaid** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date.

Dental Center Fees:

- All **Uninsured patients** will be billed up to **$30** for each visit (with maximum fee of **$120** to complete all treatment and/or repair during the current school year).
- All patients with private dental insurance will be billed at the HealthPoint full fee schedule rate. **HealthPoint does not bill any private dental insurance.**
- **Medicaid** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date.

The **School Based Health Center** can provide many services including:

- Well-child exams, school physicals, sport physicals
- Sick visits, prescriptions
- Immunizations (for Medicaid and uninsured students)
- Over-the-counter medications (ie: Tylenol)
- Assistance in management of chronic illnesses
- Providing and/or connecting students with mental health services
- Vision screenings

The **School Based Dental Center** is staffed by a dentist and hygienist and can provide many services including:

- Comprehensive Exam
- Cleanings
- Fluoride and Sealant Treatments
- Most dental procedures performed in a dental office
- Over-the-counter medications (ie: Tylenol) for dental pain

If you have any questions, please contact your child's school. *Thank you for allowing us to serve you and your student.*

Circle one: Mary A. Goetz Elem
Ludlow High School
Grade: _____

Please complete and return if you are enrolling your child for our school based dental program.

Please follow the instructions below – Initial Boxes to Sign Up for Services

Please read each option carefully and Initial boxes to tell us when and how to schedule appointments for your child. Only initial boxes where you would like to give consent. Be sure to sign below where you see the grey arrow ⇨

☐ *Schedule my child for the next available dental appointment. Your child will receive a comprehensive exam, x-rays, a cleaning, and a treatment plan. After this initial exam and cleaning, your child will bring home the treatment plan with consent forms if any treatment is needed after the initial exam. A written summary will be sent home at each visit.* ***This will be considered your confirmation to schedule the initial visit and provide a comprehensive exam, x-rays, and cleaning.***

☐ *My child was treated at the school based health dental office during the 2016/2017 school year. Please schedule my child when they are due for their 6 month check-up for a cleaning, an exam, and x-rays. Your child will bring home the treatment plan with consent forms if any treatment is needed after the initial exam. A written summary will be sent home at each visit.* ***This will be considered your confirmation to schedule the initial visit and provide a comprehensive exam, x-rays, and cleaning.***

*Date of last dental visit:*_____

*Dentist Name:*_____

☐ *Enrollment for my child is for emergency treatment only. My child has a dentist and I do not want my child to have cleanings or routine exams and services at the school.*

☐ ***Initial here only if you want to be present for your child's dental treatment****. Appointments are available from 8:30 to 3:00 on scheduled days. If not checked then the initial visit will be scheduled at the first available appointment following your enrollment selection above at a date and time coordinated by the school to minimize disruption to your child's learning during school hours.*

☐ ***Initial here only if you give permission*** *In the absence of the dentist for the hygienist working under the supervision of the dentist assigned to the school to do a cleaning and oral health education at the school.*

☐ ***Initial here only if you give permission*** *for your child to receive over-the-counter medications (ie: Tylenol) for dental related pain.*

⇨ *Print Patient/Student Name:*_____ *DOB:*_____

_____ _____

Parent/Guardian Signature *Parent/Guardian Printed Name*

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Circle one: Mary A. Goetz Elem
Ludlow High School
Grade_____

School Based Health Center Patient Profile

Student Name:_____ **Date of Birth:**_____ **Male / Female**

Address:_____ **Social Security #:**_____

City/Zip:_____ **Preferred Language:** English_____ Spanish _____

You agree we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Home Phone Number:_____ **Parent Cell Phone Number:**_____

Parent Work Phone:_____ ***Parent Email Address:**_____

** A "My Chart" account will be created for children age 3-12 if you provide an email address. A PIN number to activate your "My Chart" feature and instructions will be sent home in a sealed envelope with your student. For more information call 859-655-6104.*

Race: [ ] White/Caucasian [ ] Black/African American [ ] More than One Race [ ] Asian [ ] Native American [ ] Other

Ethnicity: [ ] Hispanic [ ] Non-Hispanic **Your Relationship to Child:** [ ] Parent [ ] Foster Parent [ ] Legal Guardian

PARENT OR GUARDIAN INFORMATION:
Name:_____
Address:_____
City / Zip:_____

BILLING TO INFORMATION:
Check here [ ] if same as Parent/Guardian
Name:_____
Address:_____
City / Zip:_____

Please list your total household annual income

$ _____ # of People in Home _____

Income information is collected to support having health and dental programs in the schools. All district students are eligible.

I wish to enroll my child for: ☐ Medical Services ☐ Dental Services* ☐ Medical and Dental Services*
***Complete the Dental Enrollment Form for the next available appointment to be scheduled**

Medical Fees

- All patients who do not have Medicaid, Medicare or Private medical Insurance will be self-pay and will be billed $20 per medical visit at the school based health center. Vaccinations are included in the $20 visit copay.
- HealthPoint will bill Anthem, United HealthCare, and Humana plans if there is no PCP or a HealthPoint Provider is selected as the PCP (preferred provider). You will be billed for the insurance plan copay.
- Any patient with private insurance except a plan above will be billed $55 per medical visit. Vaccines are an additional fee. No other private insurances are accepted or billed by HealthPoint.

Dental Fees

All patients who do not have Medicaid, Medicare or private dental insurance will be self-pay and will be billed up to $30 per dental visit at the school based dental center, with a maximum of $120 per school year (please see the cover letter for more details). Any patient with private dental insurance will be at the full dental fee rate, call 655-6104 for prices. **No private dental insurance is accepted.**

My child has (Check All That Apply):

NO insurance ☐

Private medical insurance ☐ *circle if:* **Anthem/UHC/Humana/Other ID #:**_____ Group #_____PCP:_____

Private dental insurance ☐ **PRIVATE DENTAL INSURANCE IS NOT ACCEPTED**

Medicaid ☐ *circle if:* **Wellcare, Aetna, Anthem, Humana, Passport ID # Required:**_____

A billing statement for private insurance patients and self-pay patients will be mailed to the billing information address above. Payment is expected in 20 days.

Consent to Treat A Minor Child

Completing this section will allow HealthPoint providers to examine and treat the minor child named below for simple illnesses or routine physicals including immunizations without a parent or guardian being present at the office or school health center.

Print Child's Name:_____ **Birth Date:**_____

I, _____, the parent/guardian of _____, give consent for ongoing assessment/evaluation/treatment of my child at HealthPoint offices, including school health centers. Evaluation and treatment of the child at the office will be done by a regular HealthPoint Provider. I give consent for the following dental, physical and/or mental health services to be performed at HealthPoint including school health centers:

- Assessment, diagnosis, evaluation, and treatment of the child even if a parent or guardian cannot be present
- Treatment of the child may include administration of any over-the-counter medications (e.g., pain relievers, cough suppressants, etc.) except the following: _____
- Routine lab work such as a strep screen or urine check.
- Routine immunizations as required by the State.
- Routine physicals, acute illness, follow ups
- Dental exam and procedures including x-rays, sealants, extractions, fillings, drilling, dental hygiene (amalgam or composite), and administration of local and topical anesthetic

The parent or guardian will be contacted for permission before additional things may be done. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

The following person(s) listed have my permission to bring/send my child to the school health center office for treatment:
The School Nurse, Teacher, School Administration and other school personnel may send my child for school based health services, or the parent or student, if age 18 or older, can contact HealthPoint or the school to schedule an appointment.

Others (Please Print Name / relationship to child):_____

____ (Please initial) **I decline to give permission** for anyone to bring my child to the office for treatment except for school personnel. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

Release of Information

To promote continuity of care, I authorize HealthPoint Family Care to release a copy of records created at school based health visits to the primary care provider listed below and any other health care provider involved in the patient's care.

Primary Care Provider (PCP):_____ PCP Phone:_____

Authorizations

I certify the above information is correct. I hereby consent to treatment including whatever test or procedures may be directed by the medical or dental provider. I also consent to all state required immunizations. I authorize HealthPoint Family Care, Inc. to bill my insurance for services rendered. I further authorize the release of my medical and/or dental information to my insurers or responsible party. I understand that I will be responsible for all bills if there is not active Medicaid or Medicare. I authorize HealthPoint to release health records to the school required for enrollment including school physicals and immunization records. I understand it is my responsibility to notify the school based health office about changes in guardianship, address, or phone number. A new form must be filled out for change in permission status for Treatment of a Minor Child.

Enrollment for the 2017/2018 School Year

Signature of Parent/Guardian:_____ Print Name:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Parent/Guardian:_____ Print Name:_____ Date:_____

HealthPoint Family Care Patient Name:_____ Date of Birth:_____

Who is completing this form:_____**Signature:**_____

Relationship to student: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Guardian [ ] Foster

I understand that it is my responsibility to notify the office about changes in health history.

History	Child	Mother	Father	brother/sister	Grandfather	Grandmother	History	Child	Mother	Father	brother/sister	Grandfather	Grandmother
Abnormal bleeding							Heart murmur						
Aids/HIV infection							Hepatitis						
Alcohol/drug abuse							High blood pressure						
Allergies							High cholesterol						
Anemia							Acid Reflux / Heartburn						
Anxiety							Immune System Problems						
Arteriosclerosis							Implant, prostheses, artificial joints						
Arthritis							Kidney trouble						
Artificial heart valves							Lead poisoning or exposure						
Asthma							Liver disease or Jaundice						
Back injury							Low blood pressure						
Blood or Bleeding disorder							Mitral-valve prolapsed (MVP)						
Bowel problems							Muscle problems						
Breathing problems							Painful swollen joints						
Bronchitis							Persistent cough						
Cancer or tumor							Persistent diarrhea						
Cough that produces blood							Persistent swollen glands in neck						
Damaged heart valves							Problems with mental health						
Depression							Recent weight loss						
Diabetes							Respiratory Problems						
Emotional problems							Rheumatic heart disease						
Emphysema							Sexually transmitted disease						
Epilepsy or Seizures							Sinus trouble						
Fainting Spells							Skin problems						
Gallbaldder or stones							Stomach problems						
Hay fever							Stomach ulcer						
Hearing or speech problem							Stroke						
Heart attack							Thyroid problems						
Heart disease or problems							Tuberculosis						
Other:							Vision problems						
Other:							Other:						

Is your child pregnant or nursing? [ ] Yes [ ] No	Does your child wear contact lenses? [ ] Yes [ ] No
Is your child allergic to any medications? Yes No	**Does your child have environmental or food allergies? Yes No**
Allergy:	**Reaction:**

What are your child's main health concerns:_____

What are your child's main dental concerns:_____

HealthPoint's risk assessment is a tool for our providers to partner with you to promote a healthy lifestyle for your child!

Surgeries and Hospitalizations in last 5 years: Check if None ☐ [ ] PE tubes [ ]Radiation Treatment [ ] Tonsillectomy [ ]oral/IV bisphosphonates [ ] Valve Replacement Other:	Child's Grade in School?____ # days absent this year? ___ How are they doing in school? [ ] doing well or [ ] poor Does the child live in a home built before 1970? Yes No Does anyone in the home smoke? [ ] Yes [ ] No Who smokes in home? Mother Father Sibling Other Is there a gun in the home? [ ] Yes [ ] No Any concerns about alcohol or drugs? [ ] Yes [ ] No
Does your child use tobacco: Yes No if "yes" [ ] Cigerette [ ]Smokeless Amount: ___pack(s)/can(s) per [ ] day or [ ] week How many years?	Has the child been physically abused? Yes No Has the child been sexually abused? Yes No Other concerns:
Preferred Pharmacy: _____ Pharmacy phone number: _____ Pharmacy city: ***Prescriptions are sent electronically to the pharmacy***	Primary Care Physician: HealthPoint ☐ or list below Name of physician or group: _____ Phone number: _____ Date of last physical: _____
Specialists Caring for Your Child: **Check if None** ☐	Name of Dentist: _____ Dentist phone number: _____ Date of last dental exam:

Current Medications prescription, over the counter, or herbal — Check if no medications ☐	**Instructions** (1 time a day, 2 times a day)	**Dose** (# mg, mg/mm or unit)

Child's parents are: [ ] Married [ ] Separated [ ] Divorced [ ] Other

Who's the primary Caregiver for this child: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Other

What are custody arrangements?

Immediate Family Name:	**Age**	**Current Health?**	**Lives With Child?**
Mother		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Father		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Guardian		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no

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Vaccine Resources Acknowledgement

If you wish to receive more information regarding required and recommended vaccines you may contact HealthPoint directly by calling 859-655-6104 or visit the website of the Centers for Disease Control and Prevention (CDC) at www.CDC.gov.

You may view or print an immunization schedule to be aware of which vaccines your child should receive from ages 0-18 as well as recommended adult vaccines by visiting https://www.cdc.gov/vaccines/schedules/index.html.

The CDC also provides Vaccine Information Statements (VISs) which are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to vaccine recipients. You may view or print the most current VISs at https://www.cdc.gov/vaccines/hcp/vis/index.html.

Authorizations

Federal law requires that healthcare staff provide or advise how to download or view a copy of Vaccine Information Statements to a patient, parent, or legal representative before each vaccine and before each dose of specific vaccines if more than one dose in series.

I acknowledge by signing below that I have been made aware of where to obtain vaccine resources and the most recent Vaccine Information Statements prior to my child (or myself if over 18) being administered vaccines in the school based health clinic.

Signature of Parent/Guardian:_____ Print Name__ _____Date_____