Family Health Centers

Care for your Health & Wellness

Family Health Centers - Iroquois High School

Tel: (502) 380-5201

4615 Taylor Blvd, Louisville, KY 40215

www.fhclouisville.org

High Quality Care Where Everyone is Welcome

School Based Clinic Consent Packet

There is a Family Health Centers Clinic located in your child's school!
We offer many integrated services including:

Sick Visits	Physical Exams
Sports Physicals	Immunizations
ADHD Services	Behavioral Health Services

To Sign Up

- ☐ **Sign and return the attached forms to your child's teacher or the clinic.**
- ☐ Fill out the insurance section OR send a copy of child's insurance card.
- ☐ Sign *Proof of Income for Sliding-Fee Discounts* and return proof of income to your child's teacher or the clinic.

Family Health Centers School Based Clinics accept all types of insurance including Medicaid.

If you or your child does not have insurance, we can help. Call Family Health Centers Outreach and Enrollment today at (502) 772-8182 to find out if you or your family qualifies for Medicaid, KCHIP, or other affordable health insurance options.

You can also talk to your school clinic staff about insurance questions or discounted services.

Family Health Centers School Based Clinics will provide services regardless of your ability to pay and is prepared to become your students' medical home if needed.

(Created 1/26/2024)

Patient Name: _____

Date of Birth: _____

Family Health Centers

Consent to Treat

Permission to Treatment is hereby granted to any healthcare provider employed or subcontracted by Family Health Centers, Inc. (FHC), to render such medical and minor surgical treatment as deemed necessary. This permission includes, but is not limited to testing, diagnosing, and treating HIV and other blood borne infections, sexually transmitted diseases (STDs), Substance Abuse, and Mental Health.

Authorization to Release Information is given to FHC for the purposes of Treatment, Payment, and Health Care Operations. This authorization allows FHC to release protected health information (PHI) to the extent necessary to determine payment, including special programs. This authorization allows FHC to release/share information for the purposes of internal or external audits to ensure compliance with Federal, State, local laws, regulatory agencies, and special programs. FHC is authorized to release my information to other health care providers to ensure continuity in my care.

FHC participates in an effort called Health Information Exchanges (HIE). Health Information Exchanges allows FHC to share and retrieve your health information with other health care providers. FHC currently participates with both a State and National HIE, Kentucky Health Information Exchange (KHIE) and CommonWell, and Care Quality.

Authorization to Retrieve Prescription History: I give consent and authorize my FHC provider collect prescription history and give my pharmacy and health insurer permission to disclose information about your prescriptions filled at any pharmacy or covered by any health insurance plan. I consent to allowing FHC to obtain my medication history. The medication history is a list of prescription medicines that our providers or other providers have prescribed for you. Pharmacies and Health Insurers contribute to the collection of this history. Your provider stores your prescription history in FHC's electronic health record system (EHR) and becomes part of your personal health record.

Assignment of Benefits: I authorize the payment of benefits for services provided to me by FHC, to be paid directly to FHC, for any services furnished. This authorization for payment remains in effect for one year from the date of signature regardless of changes in payer source.

Communication Consent: I consent and authorize FHC and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical good and/or services provided, exchange information, changes to health care law, health coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that I may opt out by calling 'FHC.'

Acknowledgement of Receipt: I acknowledge that I received FHC's Patient Handbook, which includes FHC's Financial Policy and detailed description of the uses and disclosures allowed by this consent, as well as other rights that I have regarding my protected health information.

_____ _____

Signature of Patient, Parent, or Legal Representative Date:

Family Health Centers
Care for your Health & Wellness

Proof of Income for Sliding-Fee Discounts

Family Health Centers (FHC) provides discounts on our services based on your household size and income. These **sliding-fee discounts** can make your healthcare and prescriptions more affordable. To get FHC's sliding-fee discounts, you must show proof of income within **30 days** of your first visit. The following items are proof of income that FHC is able to accept. Choose one of these items to bring in.

Current Pay Stubs for the most recent one month of work of everyone working in your household. 4 pay stubs if paid weekly, or 2 pay stubs if paid every other week. This can include unemployment pay-stubs.	**Letter from an organization that helps you, like a Church, stating your situation related to your income.** Letters must be on letterhead, signed, with the name and telephone number of the person writing the letter.	**Letter from your employer that provides your income amount.** Letters can be on letterhead or handwritten, they must be signed, with the name and telephone number of the person writing the letter. **The letter must include your pay rate and the number of hours worked each week.**
Letter for Social Security, SSI, Disability, Unemployment, Food Stamps or other public assistance that shows your income. Only 1 letter is needed.	**Most recent income tax filed or W2 from your employer.**	 ***Only one proof of income document is needed.***

Proof of income can be brought to any FHC location that is convenient to you. If you have dependents that will also use FHC services, please let the receptionist know so t their sliding-discount can set at the same time.

Your discounts are based on the Federal Poverty Limits (FPL). You can expect the following discount once your sliding-discount is determined:

SLIDE A	B	C	D	E	F
100% FPL	101%- 125% FPL	126-150% FPL	151-175%	176-200%	More than 200% FPL
$20/Medical visit $30/Dental visit	Pay 20% of total bill.	Pay 40% of total bill.	Pay 60% of total bill.	Pay 80% of total bill.	No Discount.

I understand that if FHC does not receive my proof of income within 30 days, I will be set to a SLIDE F and NOT receive discounts on services.

_____ _____

Patient Signature Date

School Based Clinic Registration Form

School/Teacher:_____

PATIENT INFORMATION (PLEASE PRINT)					
Last Name: **First Name:** **Middle:**			**Date of Birth:**	**Social Security Number:**	**Sex:** ❑F❑ M
Home Phone Number:	Address:		City:	State:	Zip Code:
PARENT/GUARDIAN					
Guardian #1 Last Name:	Guardian #1 First Name:		Relationship to Student: ❑Parent ❑Guardian ❑Stepparent ❑Other ❑Foster Parent	Guardian lives with student? ❑Yes ❑No	Sex: ❑ F❑M
Cell Phone:	Work Phone:		Email:	Date of Birth:	
Guardian#2 Last Name:	Guardian #2 First Name:		Relationship to Student: ❑Parent ❑Guardian ❑Stepparent ❑Other ❑Foster Parent	Guardian lives with student? ❑ Yes ❑ No	Sex: ❑ F❑M
Cell Phone:	Work Phone:		Email:	Date of Birth:	
Emergency Contact other than parent:	Emergency Contact Phone Number:		Relationship to Child:	Race: ❑White ❑ African American ❑Asian ❑Native American or Alaskan ❑Native Hawaiian or Pacific Islander	
How many people live in your home?	(Required) Total Yearly Income:		Language:	Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino	
What is your housing situation today? ❑I have housing ❑I choose not to answer this question		❑ I do not have housing (staying with others, in a hotel, shelter, living outside on the street, in a car, or in a park)			
Are you worried about losing your housing? ❑Yes ❑No ❑I choose not to answer this question					
Does your child attend Jefferson County Public School? ❑Yes ❑No					
What Pharmacy do you use?_____Street: _____ **Would you prefer to use the FHC Pharmacy located at 4112 Taylor Blvd, Louisville KY 40215? ❑Yes ❑No**					
MEDICAL INSURANCE INFORMATION: If you have a Medical Card, KCHIP Card or private insurance, please complete the information below. The insurance information can be found on the front/back of your insurance card.					
Insurance Company Name or MCO:	Medical Card Number/ID/Policy Number:		Group Number:		
Policy Holder's Name:	Policy Holder's Date of Birth: (Required)		Relationship to patient:		
DENTAL INSURANCE INFORMATION: If you have separate Dental Insurance, please complete the information below. The insurance information can be found on the front/back of your insurance card.					
Insurance Company Name or MCO:	Medical Card Number/ID/Policy Number:		Group Number:		
Policy Holder's Name:	Policy Holders Date of Birth: (Required)		Relationship to patient:		
I do agree that the completed information is true to the best of my knowledge. I also understand that by signing this form, I acknowledge that I have access to a copy of Patient Rights & Responsibilities and Family Health Centers' Privacy Notice provided at the Clinic or I may look it up on https://www.fhclouisville.org/get-health-care/for-patients/patients-rights/					
Signature of Parent or Guardian WHO HAS LEGAL CUSTODY OF THE CHILD: X			Date: X		
Printed Name:					