PRIMARY HEALTH SOLUTIONS
SCHOOL-BASED HEALTH SERVICES
ENROLLMENT PACKET

Welcome to Primary Health Solutions School Based Health Services (SBH).

This center is very unique being school based. It offers the students and community member's access to medical care when it might otherwise not be available. We operate year-round and during the school year offer **NO COST** transportation from the schools in the districts where PHS provides services, to the health centers and back. The parents/ guardians are always welcome at the appointments but are not required to be there. After the first year, only items that change need to be completed. Examples - grade in school, school building, school district, addresses, phone numbers, medical history, insurance information, etc.

Once the student's completed consent and history are received, we will begin scheduling appointments for approved services. You will receive a notice of the student's appointment time by phone or note from school. If we do not receive a request to change the appointment, we will proceed as scheduled.

- Complete the required documents and return to school with the student or drop off at the health center.
- Scheduling may be delayed if there are missing documents or information is illegible.

Please feel free to contact us during regular business hours at **(513) 454-1111 or (937) 535-5060**, if you have any questions.

STUDENT INFORMATION & CONSENT FOR SERVICES				
Today's Date: Month / Day / Year	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth: Month / Day / Year
Student's Current School:	Student's Current Building:	Student's Current Grade:	Student's Current School ID #:	

I consent to transportation services. This service includes transport/accompany to and from the SBHC by a school designee. I, the parent or guardian of the above-named student, release Primary Health Solutions, its Board members, its employees and authorized agents/representatives from any and all liability to personal injury or damage resulting from the transportation to or from the school for these purposes.

I give my informed consent for my child to participate in the following PHS school-base services:

Please check which services you wish your child to participate in:

☐ **All Services** ☐ **Medical** ☐ **Dental** ☐ **Mobile Dental** ☐ **Vision** ☐ **Telehealth**

PRIMARY CARE SERVICES

MEDICAL CARE including well child exams (includes work, daycare, and sports physicals), appropriate immunizations, tests and procedures necessary for infection control, clinical pharmacy services, appropriate behavioral evaluations, and treatment for illness or injury including over the counter medications unless emergency services are needed. Any necessary prescriptions will be sent to our PHS pharmacy which provides delivery unless the parent requests a different pharmacy.

DENTAL SERVICES

DENTAL SERVICES at the school based/mobile dental office include preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants and other preventive procedures will also be provided. The treatment plan will be provided and approved by the parents/guardian PRIOR to starting treatment.

VISION SERVICES

VISION SERVICES may include comprehensive eye examinations (including dilation), vision therapy, and fitting/ dispensing of vision correction.

By signing this consent, I agree to the terms and conditions regarding Payment for Services & Sharing of Health Information as explained in the accompanying Program Description form. I have also received and agree with the Patient Consent for use and Disclosure of Protected Health Information as explained in the Program Description form. I have received the Notice of Privacy Practices. I understand and agree that this consent will remain in effect until I revoke it or until my child is no longer enrolled in a school district where PHS provides services.

Parent or Guardian Signature or Patient/Student Signature (Only if 18 or older)	Parent/Guardian Printed Name or Patient/Student Printed Name (Only if 18 or older)	Date

PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year

☑ Birth Gender:
☐ Female
☐ Male

☑ Current Gender:
☐ Male
☐ Female
☐ Undifferentiated

☑ Gender Identity:
☐ Choose not to Disclose
☐ Female
☐ Female-to-Male (FTM) Transgender Male
☐ Genderqueer, neither exclusively Male or Female
☐ Male
☐ Male-to-Female, (MTF) Transgender Female
☐ Other, please specify _____

☑ Sexual Orientation:
☐ Bisexual
☐ Choose not to disclose
☐ Don't Know
☐ Lesbian, Gay, Homosexual
☐ Other: _____
☐ Straight or heterosexual

☑ Preferred Pronoun:
☐ Asked but unknown
☐ Declined to Answer
☐ He, Him, His
☐ Other
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (if different)	City	State	Zip

☑ Preferred Language:
☐ English ☐ Spanish
☐ French ☐ German
☐ Nepali ☐ Russian
☐ Other: _____

☑ Religion:
☐ Christian ☐ Agnostic ☐ Atheist
☐ Buddhist ☐ Hindu ☐ Unknown
☐ Islamic ☐ Scientology
☐ Other: _____

☑ Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Life Partner
☐ Other: _____

☑ Student Status:
☐ Full Time Student
☐ Not a Student
☐ Part-Time Student

☑ All that apply:
☐ Veteran
☐ Smoker
☐ None of the Above

Can we send notifications?
☑ All that Apply:
☐ Opt Out
☐ Email ☐ Phone ☐ Text ☐ Voicemail

☑ Which Contact # You Prefer:
☐ Home Phone # ( )
☐ Day/Work Phone # ( )
☐ Cell # ( )

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone # ( )

Email Address

EMPLOYMENT INFORMATION:

Employer Name	Occupation	Employer Phone #

STATISTICS REQUIRED FOR GOVERNMENTAL REPORTING:

☑ Tax Filing Status:
☐ Return Not Filed
☐ Single
☐ Married
☐ Head of Household

Is Head of Household:
☐ Male ☐ Female

☑ All that Apply:
☐ Homeless
☐ Migrant Farm Worker
☐ Language Barrier
☐ None of the Above

☑ Race: (Check all that apply)
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Declined to specify

☑ Ethnicity:
☐ Decline to specify
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No Is it on file with your Primary Care Provider? ☐ Yes ☐ No

FOR STAFF USE ONLY*

Portal Enrollment Reviewed: ☐ Yes ☐ No *If No, Reason:* ☐ Patient Already Enrolled ☐ Other: _____
Token Generated: ☐ Yes ☐ No *If No, Reason:* ☐ Patient Already Enrolled ☐ Other: _____
Reason for No Email: ☐ Declined (Refuse) ☐ Deferred (Self-Enroll) ☐ No Email

PHS Staff Name (Print) *PHS Staff Signature* *Date of Signature*

PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year_____

PARENT / RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient):

Last Name	First Name	MI	Social Security #	Birth Date Month / Day / Year	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

	Policy #	Group #	Effective	Co-Pay	Policy Holder	Relationship
Primary Insurance				$		
Secondary Insurance				$		
Tertiary Insurance				$		

HOUSEHOLD INCOME:

It is the policy of Primary Health Solutions to provide essential services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Discounts will be based on income and family/household size, only.
Please complete the following information to determine if you or members of your family are eligible for a discount.

**For the purpose of assistance, family/household is defined as: anyone who lives in the same house/address.*

Section (a): Total combined Income for all persons working in the household. **Section (b):** How often you get paid. **Section (c):** Any additional income received in the household. **Section (d):** Total number of people the household income supports.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

(a)Total Household Income before Taxes:	(b) ☑ Frequency:	(c) Other Income:	(d) Total Number of People Supported by Income:
$	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	$	

DOCUMENTATION OF NO INCOME:

If you have reported $0 household income in the section above, please explain how you are meeting your daily needs.

_____

_____

ACKNOWLEDGEMENT & CONSENT:

I understand that to determine eligibility for the sliding fee program, I must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). If Self-employed, I must submit detail of the most recent three months of income and expenses for the business. Primary Health Solutions may request additional information before the patient named above is approved for a discount.

I agree to inform Primary Health Solutions of any changes in circumstance that may affect the patient's eligibility. Any intentional false or fraudulent information provided will be grounds for denial of services for the patient. I understand the information above must be updated every twelve (12) months, or if there are any changes in family size or household income.

I have received information explaining the Sliding Fee Scale Program and I agree to follow its terms. I understand that any discount I am eligible for, will apply to all services received at any of the Primary Health Solutions practices, but not those services or equipment that are purchased from outside, including reference laboratory testing, medications, and x-ray interpretation by a consulting radiologist, and other such services. If I elect to pay the full fee or do not qualify for a discount, I may receive a bill if all services provided are not covered by the fee paid upfront.

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the provider. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Primary Health Solutions. I authorize the release of information to my insurance carrier and authorize payment directly to Primary Health Solutions. I have read and fully understand the above.

_____ _____ _____

Patient Name/Responsible Party (Print) *Signature of Patient/Responsible Party* *Date of Signature*

☐ Patient ☐ Parent ☐ Guardian

*****FOR STAFF USE ONLY*****

Income Documents Received: ☐ Yes ☐ No *If No, Reason:* ☐ One Day Slide ☐ Refused ☐ Other: _____

Documents Scanned: ☐ Yes ☐ No *If No, Reason:* _____

Insurance Card Scanned: ☐ Yes ☐ No *If No, Reason:* _____

_____ _____ _____

PHS Staff Name (Print) *PHS Staff Signature* *Date of Signature*

PRIMARY HEALTH SOLUTIONS (PHS)

Acknowledgement Of Receipt Of Privacy Practices

Today's Date: Month / Day / Year

PATIENT INFORMATION:					
Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year

We are required to give each patient a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most efficient way possible.

May we send/receive clinical information from health care providers participating in your care? ☐ Yes ☐ No

If you have an answering machine at home, may we leave a message? ☐ Yes ☐ No

May we leave a message at your work for you to call our office? ☐ Yes ☐ No

Is there a person at your house that we may leave a message with? ☐ Yes ☐ No

If yes, please provide household members name: _____

List below any person/persons authorized by you to discuss/receive/access your medical information.

	Last Name	First Name	Relationship to Patient
1.			
2.			
3.			

By signing below, I authorize PHS to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practices that I have received.

Guardian's Name (Print) _____ Relationship to Patient _____

Patient and/or Guardian's Signature _____ Date _____

☐ **Check here if you refuse to sign the acknowledgement of Receipt of Privacy Practices.**

Our Privacy Officer can be reached as follows:

Practice Address: 300 N. High Street, 4th Floor
Hamilton, OH 45011
Phone: (513) 454-1111

PHS Staff Signature _____ **Date** _____

Primary Health Solutions – Comprehensive Health Assessment – PEDS (0-18 Years Old)

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth: MM/DD/YYYY	Date Completed: MM/DD/YYYY

Current Medications: (Name and Dose)
Include prescription, over the counter medications, vitamins and herbal preparations

Allergies:
Please list all allergies including medication, environmental, food and insect

Hospitalizations, Surgeries, Serious Injuries: **Year:**

Last Exam:
Please list well child checks, dental, vision, school physicals, etc. **Provider:** **Date:**

Check conditions below that the patient has now or has had in the past:

- ☐ Abdominal Pain
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Birth Defects
- ☐ Chickenpox
- ☐ Concussion/Head Injury
- ☐ Congenital Heart Disease
- ☐ Constipation
- ☐ Developmental Delay
- ☐ Diabetes, Type: 1 2 Last HgA1c: _____
- ☐ Dizziness, light-headed or passing out
- ☐ Eczema/Hives/Skin Rash
- ☐ Epilepsy/Seizures
- ☐ Genetic Disorder
- ☐ Genital Discharge/Pain
- ☐ GERD/Acid Reflux
- ☐ Heart Murmur
- ☐ Hepatitis Type: A B C
- ☐ Kidney Problems
- ☐ Lead concerns
- ☐ Mental Health Problems Describe: _____
- ☐ Migraines/Chronic Headaches
- ☐ Scoliosis
- ☐ Sexually Transmitted Infection
- ☐ Sinus Trouble
- ☐ Stomach Problems
- ☐ Thyroid Problems
- ☐ Urinary Problems/Pain
- ☐ Other: _____

Family History: *Check if any family members have had any of the following and their relationship to the patient*

☐ Alcoholism/Drug Addiction	Relationship: _____	☐ High Blood Pressure	Relationship: _____
☐ Cancer, Type: _____	Relationship: _____	☐ Lung Disease	Relationship: _____
☐ Depression	Relationship: _____	☐ Stroke	Relationship: _____
☐ Glaucoma	Relationship: _____	☐ Diabetes	Relationship: _____
☐ Heart Disease/Heart Attack	Relationship: _____	☐ Other: _____	Relationship: _____
☐ Mental Health Problems	Relationship: _____	☐ Other: _____	Relationship: _____

Nutrition: *Please check all that apply for the patient*

- Special diet? ☐ Yes ☐ No If yes, describe: _____
- Significant weight change in the past 6 months? ☐ Gain ☐ Loss Pounds: _____
- Problems with chewing or swallowing? ☐ Yes ☐ No If yes, describe: _____
- Do you feel the patient eats as it should? ☐ Yes ☐ No If yes, describe: _____

Education:

- Current Grade in School: _____ ☐ N/A ☐ Preschool ☐ Daycare
- Has the patient repeated any grade levels? ☐ Yes ☐ No
- Has the patient had difficulties in school or identified for special education? ☐ Yes ☐ No Describe: _____

Misc:

- Is the patient hearing impaired? ☐ Yes ☐ No
- Is the patient visually impaired? ☐ Yes ☐ No
- Does the household have trouble with any of the following? ☐ Food ☐ Utilities ☐ Housing ☐ Transportation ☐ Clothing
- Cultural/Religious Needs and Preferences: _____
- Does anyone in the household or someone the patient spends a lot of time with smoke? ☐ Yes ☐ No
- When was the patient's last vaccinations given? _____
- Where were the patient's last vaccinations given? ☐ Ohio ☐ N/A ☐ Other State: _____ ☐ Other Country: _____
- Was there anything significant during the course of pregnancy or delivery? ☐ Yes, Describe: _____ ☐ No ☐ Unknown ☐ Oxygen given at birth How long? _____

Primary Health Solutions – Comprehensive Health Assessment – PEDS (0-18 Years Old)

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth: MM/DD/YYYY	Date Completed: MM/DD/YYYY

Dental: *Please check all that apply, please describe*

Prosthetic heart valve	☐ _____
Artificial joint	☐ _____
HIV/AIDS	☐ _____
Pacemaker	☐ _____
Herpes/cold sores	☐ _____
Sickle cell	☐ _____
Oral sores/bleeding gums	☐ _____
When was the patient's last dental x-rays?	_____
Does the patient brush?	☐ Yes ☐ No
How many times per day?	_____
Does the patient floss?	☐ Yes ☐ No
Has the patient had a "bad" dental experience?	☐ Yes ☐ No Describe: _____
Is the patient currently experiencing dental pain or discomfort?	☐ Yes ☐ No
Does the patient have clicking, popping or discomfort in the jaw?	☐ Yes ☐ No
Has the patient ever had a serious injury to your head or mouth?	☐ Yes ☐ No
Does the patient wear dentures or partials?	☐ Yes ☐ No

Vision: *Please check all that apply*

Itching	☐ Describe: _____
Tearing/burning	☐ Describe: _____
Double vision	☐ Describe: _____
Blurry vision	☐ Describe: _____
Floaters	☐ Describe: _____
Flashes	☐ Describe: _____
History of eye trauma or eye surgery	☐ Describe: _____
History of cataracts	☐ Describe: _____
History of glaucoma	☐ Describe: _____
Eye redness	☐ Describe: _____
Difficulties reading or learning to read	☐ Describe: _____
Loos place when reading	☐ Describe: _____

Female Health:

☐ N/A – If the patient is male OR if patient is not menstruating

Birth control: ☐ None ☐ Pills☐

Other: _____

Is the patient pregnant?

☐ Yes ☐ No ☐ Unsure

If yes, due date: _____

Age of first menstrual period: _____

Last menstrual period: _____

# of pregnancies: _____

# of living children: _____

# of live births: _____

# of miscarriage/abortions: _____

Social Habits for 12 Years Old and Older: ☐ N/A – If the patient is under 12 years old

Does the patient smoke?	☐ Yes ☐ No	Does the patient use marijuana?	☐ Yes ☐ No
Does the patient use smokeless tobacco	☐ Yes ☐ No	Does the patient use illegal drugs?	☐ Yes ☐ No
Does the patient vape?	☐ Yes ☐ No	Does the patient use alcohol?	☐ Yes ☐ No
How many times does the patient use products containing caffeine?	_____	Has the patient had more than 2 emergency room/hospital visits in the last 30 days?	☐ Yes ☐ No
Does the patient feel isolated?	☐ Yes ☐ No	Does the patient feel physically and emotionally safe where they live?	☐ Yes ☐ No
Is the patient sexually active?	☐ Yes ☐ No	How often does the patient see or talk to people you care about or feel close to?	_____
Does the patient have unprotected sex?	☐ Yes ☐ No	In the past year, has the patient been afraid of their partner or ex-partner?	☐ Yes ☐ No

Is the patient under the care of another provider? ☐Yes ☐ No If yes, provider name: _____

Is the patient under the care of a dentist? ☐Yes ☐ No If yes, provider name: _____

FOR STAFF USE ONLY

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____