



**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: / /

PARENT/RESPONSIBLE PARTY INFORMATION (Parent/Guardian Information)

Last Name	First Name	MI	Nickname	Social Security #	Birth Date / /
Billing Address (If different from residence address)		City		State	Zip
Phone Number		Email Address			

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) <input checked="" type="checkbox"/> Frequency: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	(c) Other Income: \$	(d) Total Number of People Supported by Income:
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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 AND 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
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PRIMARY HEALTH SOLUTIONS (PHS)

Acknowledgement Of Receipt Of Privacy Practices

Today's Date: ____ / ____ / ____

PATIENT INFORMATION:					
Last Name	First Name	MI	Nickname	Social Security #	Birth Date
_____	_____	_____	_____	_____	____ / ____ / ____

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 or (937) 535-5060

PHS Staff Signature _____ Date _____

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

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth:	Date Completed:
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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: **Provider:** **Date:**
Please list well child checks, dental, vision, school physicals, etc.

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

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

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

- | | | | |
|---|---------------------|--|---------------------|
| <input type="checkbox"/> Alcoholism/Drug Addiction | Relationship: _____ | <input type="checkbox"/> High Blood Pressure | Relationship: _____ |
| <input type="checkbox"/> Cancer, Type: _____ | Relationship: _____ | <input type="checkbox"/> Lung Disease | Relationship: _____ |
| <input type="checkbox"/> Depression | Relationship: _____ | <input type="checkbox"/> Stroke | Relationship: _____ |
| <input type="checkbox"/> Glaucoma | Relationship: _____ | <input type="checkbox"/> Diabetes | Relationship: _____ |
| <input type="checkbox"/> Heart Disease/Heart Attack | Relationship: _____ | <input type="checkbox"/> Other: _____ | Relationship: _____ |
| <input type="checkbox"/> Mental Health Problems | Relationship: _____ | <input type="checkbox"/> 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: _____

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? _____

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: _____

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

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth:	Date Completed:
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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 _____ Age of first menstrual period: _____

Other: _____ Last menstrual period: _____

Is the patient pregnant? Yes No Unsure # 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient use marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient use smokeless tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient use illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient vape? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient feel isolated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient feel physically and emotionally safe where they live? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often does the patient see or talk to people you care about or feel close to? _____
Does the patient have unprotected sex? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past year, has the patient been afraid of their partner or ex-partner? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____