Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center

Consent for Health Services

Thomas County Schools and Primary Care of Southwest Georgia, Inc. (PCSG) have developed a comprehensive health clinic at Thomas County Middle School (TCMS). This center is staffed with a Board Certified Family Nurse Practitioner and a Licensed Practical Nurse. Our services include diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, routine health physicals, immunizations, health education/promotion, hearing, vision and lab testing.

The primary focus of the clinic is to provide quality, accessible health care to the children of Thomas County Schools in order to impact the children's health, school attendance and academic performance.

I hereby request and authorize that:

Print Student's Name: ____ ______________

First Name Middle Initial Last Name Birth Date

the above named child receives any and all health care services available from, and deemed necessary by, the staff of the TCMS health center and their associated provider agencies. These services may include, but are not limited to, procedures such as evaluation and treatment of acute illness and injuries. Consent is also given for referral of care and if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Center and its staff.

The School-Based Health Center encourages each student to involve his/her parent or guardians in health decisions whenever possible. Consent for services is authorized for the length of time the youth is enrolled in the Thomas County School System.

I have read and understand the above information and I give permission for my child's care as described and I consent for my child to be **TRANSPORTED/ACCOMPANIED** by a school designee to and from any school within the Thomas County School System for services at the School-Based Health Center located on the campus of TCMS. I also understand that I may obtain further information regarding the health services offered by the health center by calling (229) 227-2936.

Student Name: ____ Date: _______________

(PLEASE PRINT)

Parent/Guardian Signature: __________________________________ Date: ________________

Name and Relationship of Legally Responsible Guardian (Please Print):

____ ________________________

Legally Responsible Guardian Name Relationship

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center

Permission for Release of Health Information

I_______________________________________ hereby give permission for the staff of Primary Care of Southwest GA, Inc. and my provider to give **my child's** health information to the person that I indicate below.

You may communicate with the following individual regarding **my child's** condition or course of treatment.

Name:	______________________	Name:	______________________
Address:	______________________	Address:	______________________
	______________________		______________________
Telephone:	______________________	Telephone:	______________________
Relationship:	______________________	Relationship:	______________________

I am fully informed as to the content of this form and understand the reason for this release of information. I understand that I have a right to revoke this authorization at any time. I understand if I revoke the authorization, I must do so in writing and present my written revocation to the practice.

____
Child's Name

_______________________________________ ______________________
Patient/Guardian's Signature Date

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center
STUDENT HEALTH QUESTIONNAIRE

Child's Name: ______________________________ ___________________________ ____________
Last **First** **Middle Initial**

Date of Birth: _______________________ Age: _____ Grade: ______ Child's Social Security Number: _____________________
Month/Date/Year

Today's Date: _____________________ School Name: _____________________________________
Month/Date/Year

The information you provide is **STRICTLY CONFIDENTIAL.** Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.

Family Information

Your Name	How are you related to the above named child?

1. With whom does your child live? (Check All That Apply)

   ______ both natural parents ______ stepmother ______ alone

   ______ mother ______ stepfather ______ brother(s)/ages: ____________________

   ______ father ______ guardian ______ sister(s)/ages: _____________________

   ______ adoptive parents ______ other (explain) ____

2. Does anyone else take care of your child? □ Yes □ No

   If yes, who? ____

3. Does your child have any health problems? □ Yes □ No

   If yes, what? ____

4. Where do you take your child when he/she is sick? ___________________________________

5. Where do you take your child for dental care? _____________________________________

6. Does your child have any allergies to any medications? □ Yes □ No

   If yes, what? ____Type of reaction___________

   If yes, what? ____Type of reaction___________

7. Does your child have any food allergies or intolerances to insects, environmental, latex □ Yes □ No

   If yes, what? ____Type of reaction___________

8. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? □ Yes □ No

   If yes, what? ____

9. Has your child ever been hospitalized or had surgery? □ Yes □ No

   If yes, when? ______________ What type? ____________________ Why? _________________

10. Do you have any concerns about your child? □ Yes □ No

    If yes, what? ____

11. Are the child's parents: (Please Circle Answer) Married Separated Divorced Non-Married Parents

    If divorced, when? ____

12. Do the child's parents work outside the home? □ Yes □ No

    If yes, what type of work do they do? Mother _______________ Father ________________

Family Medical History

13. Does the child's mother, father, siblings or grandparents have any of the following?

		If yes, who?			**If yes,** who?
High Blood Pressure	□ Yes □ No	____________	Learning Problems	□ Yes □ No	____________
Diabetes	□ Yes □ No	____________	Mental Illness	□ Yes □ No	____________
Lung Problems	□ Yes □ No	____________	Nerve Problems	□ Yes □ No	____________
Asthma	□ Yes □ No	____________	Drinking Problems	□ Yes □ No	____________
Heart Problems	□ Yes □ No	____________	Drug Problems	□ Yes □ No	____________
Cancer	□ Yes □ No	____________	Other ____________	□ Yes □ No	____________
Miscarriages	□ Yes □ No				

Family Health Habits

14. How often does your child use a seatbelt (car seat)? (Please Circle Answer)

A. Never   B. Rarely   C. Sometimes   D. Often   E. Always

15. Does your child ride a bicycle, skateboard or roller blade? □ Yes □ No
If yes, how often does he/she use a helmet? (Please Circle Answer)
A. Never   B. Rarely   C. Sometimes   D. Often   E. Always

16. Does your child need information about safety (strangers or unknown adults, matches, etc.)? □ Yes □ No

17. How many hours of sleep does your child get each night? ______ hours.

18. Do you feel that you live in an unsafe place? □ Yes □ No

19. Have there been any major changes in your family such as: (Check All That Apply)

___ moving ___ death of family member ___ violence or serious accident

___ physical, emotional, sexual abuse ___loss of job ___ birth ___ other

20. Do you have a gun at home? □ Yes □ No

If yes, is it locked? □ Yes □ No

21. Does anyone in your household smoke? □ Yes □ No

22. Do you currently smoke cigarettes? □ Yes □ No

If yes, how many cigarettes do you smoke per day? ______ cigarettes a day

School History

23. Did/does your child attend preschool? □ Yes □ No

24. Do you have any concerns about your child's school performance? □ Yes □ No
If yes, what? ____

25. Do you have any concerns about your child's relationships with teachers? □ Yes □ No

26. Do you have any concerns about your child's relationships with other students? □ Yes □ No

27. Do you have any concerns about your child's relationships with siblings or other family members? □ Yes □ No

28. If over 4 years old, does your child have a best friend? □ Yes □ No

29. Does your child participate in sports/exercise or have hobbies, special interests or talents? □ Yes □ No

If yes, what ________________ How often? ________________ How long? ________________

CHILD’S MEDICAL HISTORY

CHILD’S NAME___________________________________BIRTHDATE___________________GRADE LEVEL____________________

ILLNESS HISTORY

AIDS/HIV	__Yes__No
Allergies	__Yes__No
Allergic to drugs/latex	__Yes__No
Anemia	__Yes__No
Asthma	__Yes__No
Other Respiratory Problems	__Yes__No
Stomach Ulcers	__Yes__No
Abdominal Pain	__Yes__No
Constipation/Diarrhea	__Yes__No
Serious Digestive Problems	__Yes__No
Chicken Pox Age____	__Yes__No
Ear Problem	__Yes__No
Ear Infections	__Yes__No
Hearing Aid	__Yes__No
Eye Problem	__Yes__No
Wears Glasses	__Yes__No
Physical/Sexual Abuse	__Yes__No
Fainting Spells/Knocked Out	__Yes__No
Frequent Sore Throat	__Yes__No
Headaches	__Yes__No
Heart Murmur	__Yes__No
Heart Problems	__Yes__No
High Blood Pressure	__Yes__No
Thyroid Problems	__Yes__No
Diabetes	__Yes__No
Hemophilia	__Yes__No
Hepatitis	__Yes__No
Injuries (major)	__Yes__No
Musculo-Skeletal Problems	__Yes__No
Broken Bones	__Yes__No
Problems Walking	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No
Frequent Colds	__Yes__No
Lung Problems	__Yes__No
Underweight	__Yes__No
Menigitis	__Yes__No
Menstration Started Age____	__Yes__No
Menstrual Problems	__Yes__No
Premature Birth Weight______	__Yes__No
Obese	__Yes__No
Rheumatic Fever	__Yes__No
Skin Rashes	__Yes__No
Serious Acne	__Yes__No
Sickle Cell Disease	__Yes__No
Sickle Cell Trait	__Yes__No
Other Blood Disorders	__Yes__No
Seizures/Epilepsy	__Yes__No
Speech Problem	__Yes__No
Tuberculosis	__Yes__No
Cancer	__Yes__No
Other ___________________________________	

BEHAVIOR STUDY

Thumb Sucking	__Yes__No
Nightmares	__Yes__No
Bedwetting	__Yes__No
Discipline Problems	__Yes__No
Overactive/Hyperactive	__Yes__No
Shy	__Yes__No
Sleeping Problems	__Yes__No
Slow Development	__Yes__No
Learning Disability	__Yes__No
Smoker	__Yes__No
Alcohol	__Yes__No
Inhalants	__Yes__No
Other Drugs _______	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	__Yes__No
Other________________	__Yes__No

Explain any behavior or mental problems noted _______________________________
____
____

PLEASE LIST ANY PRESENT CONCERNS:
____
____
____

***Explain any illnesses marked yes:
____
____
____

DENTAL

Dental Problems __Yes__No

When was your child’s last dental visit?
____

How often are your child’s teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? __Yes __No

Has your child had any injury to the teeth or jaws? __Yes __No

Generally speaking, what has been your child’s experience with a dentist? __Good __Bad __Very Bad
No experience (the child’s first visit) ___

What is the best way to reach you, if we need to? Home Phone #_________________ Cell Phone # _______________________

Mailing Address ____

Parent Signature____ Date____________________

Parent Email Address____

Parent Date of Birth____

Emergency Contact Name____

Emergency Contact Phone Number____

PEDIATRIC REGISTRATION FORM

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
229-227-2936 Phone 229-225-5284 Fax
www.pcswga.org

CHILD'S INFORMATION - SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

CHILD'S FULL NAME (FIRST MIDDLE LAST)			CHILD'S GENDER ☐ MALE ☐ FEMALE	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER ________	CHILD'S DATE OF BIRTH
PRIMARY HOME ADDRESS (NO P.O. BOXES)			FAMILY'S PRIMARY EMAIL ADDRESS		
CITY	STATE	ZIP	CHILD'S ETHNICITY ☐ DECLINE ☐ HISPANIC ☐ NON-HISPANIC	CHILD'S RACE ☐ DECLINE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIN OR PACIFIC ISLANDER ☐ WHITE ☐ OTHER ______________________________	
PRIMARY HOME PHONE	PRIMARY CELL PHONE		PRIMARY WORK PHONE		
Do you prefer to be reached on: (1st contact)	PRIMARY HOME PHONE ☐ PRIMARY CELL PHONE ☐ PRIMARY WORK PHONE ☐		CHILD'S SOCIAL SECURITY NUMBER		

MOTHER or LEGAL GUARDIAN'S INFORMATION / FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

MOTHER/GUARDIAN'S FULL NAME			FATHER/GUARDIAN'S FULL NAME		
MOTHER/GUARDIAN'S SOCIAL SECURITY #	MOTHER'S MAIDEN NAME OR GUARDIAN'S RELATION TO THE PATIENT *(IFAPPLICABLE)*		FATHER/GUARDIAN'S SOCIAL SECURITY #	CHILD LIVES WITH *(CHECK ONE)* ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER_____________________________	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED	
MOTHER/GUARDIAN'S MAILING ADDRESS ☐ *CHECK IF SAME AS CHILD*			FATHER/GUARDIAN'S MAILING ADDRESS ☐ *CHECK IF SAME AS CHILD*		
CITY	STATE	ZIP	CITY	STATE	ZIP
MOTHER/GUARDIAN'S HOME PHONE	MOTHER/GUARDIAN'S CELL PHONE		FATHER/GUARDIAN'S HOME PHONE	FATHER/GUARDIAN'S CELL PHONE	
MOTHER/GUARDIAN'S EMPLOYER	MOTHER/GUARDIAN'S WORK PHONE		FATHER/GUARDIAN'S EMPLOYER	FATHER/GUARDIAN'S WORK PHONE	
MOTHER/GUARDIAN'S EMAIL ADDRESS			FATHER/GUARDIAN'S EMAIL ADDRESS		

Please ✓ your annual household income range: ______ Less than $12,000 ______ $12,000-$18,000 ______ $18,000-$25,000 ______ Over $25,000

Total number in household (number of people living in home): ______

INSURANCE INFORMATION - THIS SECTION MUST BE COMPLETE OR PAYMENT IN FULL IS DUE AT TIME OF SERVICE

A copy of your child's Insurance Card is required at time of service.

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S GROUP / POLICY NUMBER	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER
SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S GROUP / POLICY NUMBER	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER

EMERGENCY CONTACT INFORMATION

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone your child does not live with and who we have your permission to contact if necessary.

NAME OF PERSON NOT LIVING WITH YOUR CHILD	RELATIONSHIP TO CHILD	EMERGENCY CONTACT'S PHONE NUMBER

PREFERRED PHARMACY

NAME OF PHARMACY	ADDRESS OR INTERSECTION	PHONE (IF KNOWN)	FAX (IF KNOWN)

PLEASE CONTINUE ON THE BACK

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
229-227-2936 Phone 229-225-5284 Fax
www.pcswga.org

PEDIATRIC REGISTRATION FORM

FINANCIAL POLICY & CONSENT FOR TREATMENT

Financial Policy

By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present on the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balances.

- We file claims to participating insurance companies as a courtesy to you - you are and remain responsible for ensuring full payment. We will bill your insurance company if we are in network and if your insurer accepts claims electronically. You are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. Patients are considered self-pay for services covered by worker's comp or auto insurance.
- If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days after the date of service and you must pay the outstanding balance in full.
- Patients with an outstanding balance of 90 days or more must arrange an acceptable payment plan or their account. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our office to request assistance before your account becomes delinquent.
- Occasionally during scheduled well child visits a physician will diagnose and treat a problem. When appropriate, problems addressed during preventative exams will be billed as routine care in addition to the well child visit. Some insurance policies do not cover both services. In the event that you schedule a well child visit and a problem is addressed, you may be responsible for an additional co-pay, co-insurance, deductible, or denial after the visit.
- We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. It is your responsibility to know if you have coverage before services are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis codes in order for it to be paid.
- All co-pays are due at the time of service regardless of who brings the child in for the appointment. Failing to pay your co-pay at the time of service may result in your appointment being rescheduled.
- When paying with a personal check, a valid photo ID of the check signer is required. Only checks that have been printed with the check signer's name and address will be accepted. All returned checks are assessed a $35.00 service charge. Postdated checks are not accepted.
- If for any reason you must cancel or reschedule your appointment(s), please notify our office at least 24 hours in advance. Patients that no-show 2 times in 6 months will not be allowed to schedule appointments. You will be required to walk-in and wait for an appointment to open up. If you are more than 1 5 minutes late for your appointment, you will need to reschedule your appointment.

Consent for Treatment

As the parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Primary Care of Southwest Georgia, Inc.. (PCSG) I hereby authorize PCSG to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to PCSG on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

Consent for Medical Treatment: I voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary or advisable by the health care provider (HCP) including seronoloy testing for Hepatitis B, C, HIV, and UA's in the event my blood and or/body fluids is suspected to have come in direct contact with any health care worker, to determine if my blood has contagious viruses. I understand that all the patients will see a HCP and/or Licensed Clinical Social Worker and that PCSG participates in preceptorships and clinical rotations for pre-med, medical, nursing, and medical assistant students. All student evaluations are under the direct supervision of the attending physician/provider.

I consent to have medical students (NP, PA, RN, LPN, MA) present in the room for observation and treatment. YES _____ NO ______

Authorization to Release Medical Information: I hereby authorize PCSG to release any information, including Behavioral Health, necessary for my course of treatment. I understand that my records are protected by HIPPA Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the provider.

Acknowledgement of Privacy Notice: PCSG Notice of Privacy Practices is and was available to read.

Authorization to Obtain External Prescription History: I authorize PCSG to view my external prescription history in the RxHub service (including medications from all physicians past and present) in order to document allergic reactions, adverse side effects, dosages and other pertinent information to ensure proper treatment and management of my health care.
I consent to exchange data with external care settings for a more detailed medical record to assist in my care and treatment.

Parent/Guardian's Name & Signature

Print Parent/ Guardian's Full Name

Parent/ Guardian's Signature

Date of Signature

Child's Name

Print Child's Name

Date of Birth

AUTHORIZED INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD FOR MEDICAL CARE AND RECEIVE MEDICAL RESULTS

Please list anyone who has your permission to bring your child to our office for medical care and/or vaccinations in your absence and/or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPAA requirements, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE
NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School Based Health Center

Summary of Notice of Privacy Practices

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We have a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and obligations regarding the use and disclosure of your medical information. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Parties Following the Notices: The Notice will be followed by Primary Care of Southwest Georgia, Inc. and its affiliates, together with their health care professionals, staff and volunteers, and those participating in managed care networks with Primary Care of Southwest Georgia, Inc., and other legal entities that provide services to Primary Care of Southwest Georgia (PCSG).

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons including:

- Treatment
- Bill for your services
- Health care operations
- Health oversight activities
- Public health purposes
- Auditing
- National security & protective services
- Research
- Worker's Compensation; Law enforcement purposes
- Lawsuits and disputes
- Hospital directories
- Fundraising activities (with written consent from patient)
- Activities of managed care networks which we participate
- Activities of our affiliates
- Appointment reminders
- Comply with the Law
- To avert a serious threat to health/safety
- To corners, medical examiners & directors
- To military command authorities
- As required by law
- Individuals involved in your care or payment.

Your Privacy Rights:
You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain use of your health information
- The right to inspect and copy certain medical information that we maintain about you either paper or electronic medical record.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of your health information.
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated.

Additional Information: Upon request you may review our detailed Notice of Privacy Practices for further information regarding exercising your privacy rights or if you object or request a limitation of the referenced uses of disclosure.

Changes to the Notices: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Secretary of the US Department of Health and Human Services

Patient Acknowledgement: I acknowledge that I have been made aware of the Notice of Privacy Practices for Primary Care of Southwest Georgia. I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

____
Child's Name

Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date

FOR PCSG PERSONNEL ONLY: (Complete if patient acknowledgement is not obtained)
The patient was made aware of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging awareness of the notice, an acknowledgement was not obtained because____.

PCSG Representative	Date