COPLIN HEALTH SYSTEMS

Student/Patient Registration

School Name: ________________________ Grade: ____________

Basic Information

First Name	Last Name	MI

Gender ☐Female ☐Male ☐Unknown	Date of Birth	Social Security Number
Home Phone #	Cell Phone #	Work Phone #
Email Address	☐No-email	Preferred Method of Contact: ☐Text ☐Home Phone ☐Email

Mailing Address	City	ST	Zip

Parent/Guardian	Relationship	DOB	Phone #	Email
1)________________	1)______________	1) ________	1)____________	1)____________________
2)________________	2)______________	2) ________	2)____________	2)____________________

If there is a change in legal guardianship, court-ordered guardianship papers must be submitted with the updated registration form to ensure compliance with Coplin Health Systems' policies and applicable state laws.

Student Lives With:
☐Mom ☐Dad ☐Both ☐Other: ____

Preferred Language	**Primary Care Provider**
Preferred Pharmacy	Preferred Pharmacy Address

Responsible Party: (Responsible for bill): ☐Same as Above

Name:	Date of Birth:	Phone:

Relationship to Patient	Mailing Address of Responsible Party

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs, and HIV / AIDS information).

Name of Emergency/Alternate Contact	Date of Birth	Phone #
Relationship to Patient	Address of Contact	May we leave a message? ☐Yes ☐No

Permission to Speak and Treat

I ____________________ authorize Coplin Health Systems to share my personal health information with the named persons below.

Please check the box to identify the information Coplin Health Systems is authorized to share with each named person.

Name: ___________________ Date of birth: _________Relationship to patient: ______________ ☐*Permission to Treat
Phone: _____________________ ☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

Name: ___________________ Date of birth: _________Relationship to patient: ______________ ☐*Permission to Treat
Phone: _____________________ ☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

Name: ___________________ Date of birth: _________Relationship to patient: ______________ ☐*Permission to Treat
Phone: _____________________ ☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

*By checking the “Permission to Treat” box, I authorize the individual named above to accompany the listed patient for healthcare services and to consent to treatment on the patient's behalf, as necessary.

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Student/Patient Registration

Insurance Information ☐ Patient does not have insurance

Primary Insurance Name	Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer
Secondary Insurance Name	Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer

☐I would like to request for information regarding Coplin Health Systems Sliding Scale Fee
☐I would like to request assistance from Coplin Health Systems on obtaining insurance

Coplin Health Systems is a Federally Qualified Health Center, and we qualify for special pricing and discounted costs to our patients. To ensure that we continue to receive this designation and funding, we value gathering specific information about the population that we serve. We ask that you assist us by completing the following information.

How many people are currently living in your household? (Circle one)
1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income? (Circle one)
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000 $3001-$3500
$3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

Household Status
☐Own my home ☐Rent ☐Live with someone ☐In Shelter ☐Transitional ☐Homeless

Military Status
☐Not a Veteran ☐Veteran ☐Active Service

Disability Status
Do you have a disability as identified by the Americans with Disabilities Act? ☐Yes ☐No

Ethnicity
☐Not Hispanic/Latino ☐Hispanic/Latino ☐Decline to Specify

Race
☐White ☐Black ☐American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander
☐Asian ☐Native American, or Other if so list: _____

Sexual Orientation
☐Straight ☐Lesbian/Gay ☐Bisexual ☐Other ☐Don't know ☐Choose not to disclose ☐Unknown

School	Student Status ☐Student ☐School Employee ☐Community Member

Current Medication and Health Information

Allergies:

Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

Well Child Exam Information

Date of last well-child exam	If your child has not seen a doctor within the last year, would you like your child to have a well-child exam at our wellness center or mobile unit? ☐Yes or ☐ No

Portable Dental Consent

The portable dental unit visits schools twice a year (fall and spring) for dental exams, fluoride treatments, cleaning, and sealants. Services utilized through the Portable Dental Unit will be billed to your insurance. If you do not have coverage, the sliding fee scale may provide a discount for your child to be seen by the Dental Hygienist and/or Dentist. To see if you qualify for this reduced rate, you must complete the income section of the enrollment.

If your child has not seen a dentist in the last year, would you like your child to have a dental cleaning with our mobile dental services? ☐Yes or ☐No Dental X-rays ☐Yes or ☐No Fluoride Varnish ☐Yes or ☐No

If yes, do you want your child to have dental sealants on the same day as cleaning? ☐Yes or ☐No

If your child already has a dentist, he/she does *not* qualify for this program.

Your insurance will not cover the fees of both your regular dentist *and* this program.

Name of Current Dentist	Date of last dental exam

Dental Insurance Information ☐Patient does not have dental insurance

Dental Insurance:	Insurance ID Number:	Group Number
Insurance Phone Number:	Policy Holder Name:	
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer

Special Consents

☐Yes ☐No - I agree to allow Coplin Health Systems access the patient's prescription history

☐Yes ☐No - I agree to have nursing and/or medical students present during the care of the patient

☐Yes ☐No - I agree to allow Coplin Health Systems to record the visit for accuracy of documentation (This is only stored for a temporary period, and may be specifically declined during the visit for any reason, by letting the provider know)

Scheduled Appointment Cancellation Requirement Acknowledgement

Coplin Health Systems strives to provide access to quality care for medical, pediatrics, dental and behavioral health services. In that effort, the organization works to actively reduce missed appointments and no-show appointments which are those appointments that are not kept or cancelled prior to the time of the appointment.

To assist in ensuring patients stay alert to their scheduled appointments, Coplin Health Systems uses automated appointment reminder services that contact scheduled patients by phone, email or text. Please verify that all contact information is up to date with the patient representative when checking in for appointments.

Patients that need to reschedule or cancel an appointment are asked to notify the office where they are scheduled at least 24 hours prior to the appointment time. If this falls on a weekend, please leave a message on the office voicemail service. This will allow staff time to fill the vacancy in the provider's schedule so others in need can be seen.

Please note that if a patient misses two or more scheduled appointments without canceling at least 2 hours prior to the appointment, a letter will be sent to the patient to offer assistance in addressing possible barriers preventing the patient from keeping the scheduled appointment.

Please be aware that if a third scheduled appointment is missed without being cancelled at least 2 hours prior to the scheduled visit, the patient will only be able to be seen through available Same Day appointment openings as they are available for a twelve-month period beginning from the date of the first missed appointment that was not canceled as required. This appointment may be with a provider other than the patient's primary care provider depending on availability. This means that for the remainder of the twelve-month period, the patient can only be seen if an available same day appointment is open on the day the patient calls to schedule.

I acknowledge the Appointment Scheduling Requirements: **(initial)** _____

Telehealth Consent

I understand that medical and behavioral health services may be provided via telehealth using two-way audio-visual technology, which differs from in-person visits, as the provider will not be in the same room. I have the right to refuse or stop participation in telehealth services at any time. Should I choose not to participate, or if the provider determines the technology does not meet the standard of care, I understand that I may need to schedule an in-person visit or seek care elsewhere, including emergency care, depending on the urgency of my condition. I understand how this technology will work, and I recognize that technical difficulties or interruptions may occur during a telehealth visit. I understand if I have questions prior to a telehealth visit, I can reach out to have those questions addressed.

During telehealth sessions, I will be informed of anyone present in the room with my provider, and such individuals will only be involved if necessary to assist in my care. I understand that providers participating in my care are licensed in the state where they are located, and if they are not licensed in the state where I am located, I still consent to receive services. I am responsible for any applicable co-pays or coinsurance. My provider may request for consent to take photographs during the session for my care. My provider may also request to record the visit which will be stored for a temporary period, to assist with documentation, which will be treated as protected health information under applicable laws. Confidentiality protections apply, except in situations involving suspected child or vulnerable adult abuse, threats of harm to self or others, or as required by law. Information may be shared within Coplin Health Systems' integrated Behavioral Health program as permitted by law.

This consent will remain in effect until the student is no longer enrolled at the school listed on this registration or until it is revoked in writing by the parent or legal guardian.

I understand the above notice and consent for the patient named above **to receive telehealth services**, as needed, for **medical services (initial)** _____ and/or **Behavioral Health services (initial)** _____.

Consent for Services

As the legal parent/guardian, I voluntarily consent for my child to receive services from Coplin Health Systems through the school-based health program and/or mobile unit program. I understand these services may include, but are not limited to, acute care, preventive care, screenings, treatment, care coordination, and health education as needed.

I authorize Coplin Health Systems, the school nurse, and, if applicable, my child's primary care provider or other treating professionals to exchange relevant health information for the purposes of care and treatment.

I acknowledge that I have been given access to Coplin Health Systems' HIPAA Notice of Privacy Practices, and I understand that I can obtain a copy from a Patient Representative, view it on the lobby wall, or access it on the website at coplinhealth.com, which explains how my child's health information may be used and shared. I understand and agree that my child's health will be shared with the WV and OH Health Information Networks, CommonWell, CareQuality and Surescripts, and that I may opt out in writing.

I authorize Coplin Health Systems to bill Medicaid, insurance, or other payors for services provided, and I accept responsibility for any charges not covered, including co-pays, deductibles, and non-covered services. I understand that if the insurance information is not correct, or the patient does not have insurance, that I am responsible for any charges. I understand that Coplin Health Systems has a sliding fee discount program, and I can complete an application to see if I would qualify which is based only on income and household size. I understand that no patient will be denied health care services due to an individual's inability to pay. I permit the patient's information to be used for claims processing, care coordination, or audits.

I agree that Coplin Health Systems may use the contact information provided for communication related to appointments, billing, or other health matters. I certify that all the information I have provided is accurate and that I am consenting to treatment for the identified patient. I understand that this consent remains effective until the patient changes schools from the one indicated on this form, unless it is revoked in writing, except for services already rendered. I understand that if legal guardianship changes, I must submit a new consent form and guardianship documentation.

Parent or Legal Guardian Signature	Student Signature (If over 18)
Print Name	Date