Bassett Healthcare Network
School-Based Health

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student Information

Student's Name: Date of Birth: / / ☐ M ☐ F ☐ Other

Preferred Name: Student Email:

Home Phone #: Student's Cell #: Social Security #:

Address:

City: Zip: County: Religious Preference:

Student's Mother's Maiden Name:

Primary Care Provider/Address

Pharmacy/Address:

Name of School District: Grade:

Parent/Guardian Information

Parent/Guardian Name: DOB ☐ Mom ☐ Dad ☐ Guardian	Parent/Guardian Name: DOB ☐ Mom ☐ Dad ☐ Guardian
Home #:	Home #:
Work #	Work #
Cell #:	Cell #:
Address (If different than student):	Address (If different than student):
E-Mail:	E-Mail:

Emergency Contact (other than parent/guardian)

Name: Relationship to Student:

Home #: Cell # Work #:

Address:

Health Insurance Information

Does the student have Health Insurance? ☐ Y ☐ N

If yes, please continue. If no, would you like help getting health insurance? ☐ Y ☐N

PLEASE SEND A COPY OF YOUR INSURANCE CARD, BOTH FRONT AND BACK (or stop in and we'll make a copy for you)

Insurance Name: Is this Child Health Plus? ☐ Y ☐ N

Subscriber #/Policy #: Group #: Effective Date:
If there is a two-digit # next to student's name please provide after policy #.

Policy Holder's Name: DOB: SSN:

Employer of Policy Holder: Relationship to Student:

Copay Amounts: **(SBHC does not collect copays)**

Medicaid #: Access #: Seq #:

Effective Date:

EN RO LME NT SBH C

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student's Legal Name: _____ Date of Birth: ___/___/___ Sex: M / F / O

I give consent for my child to receive oral /health care services including telemedicine. I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State law. New York State law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, reproductive health or mental health issues.

I WILL NOTIFY THE SCHOOL-BASED HEALTH CENTER IN WRITING IF I WISH TO REMOVE MY CHILD FROM THE HEALTH PROGRAM.

In order to provide optimal health care to your child, it is necessary for the School-Based Health Center staff and school nurse to regularly communicate and share medical and health related information. I hereby authorize the release of information from the School-Based Health Center to the school nurse and the school nurse to the School-Based Health Center. I understand that the information to be released is confidential and protected from re-disclosure. It will not be released except to the School-Based Health Center or school nurse without a completed authorization to do so. It may also be necessary, if your child is receiving services from a SBHC Mental Health clinician, for information to be discussed with other clinicians in the SBH mental health program as part of the case supervisory process. I understand that any shared information is confidential and protected from re-disclosure.

X _____ Date: ___/___/___

Parent/Guardian Signature

Please be sure to read and sign the authorization below.

***Authorization to release information*:** I hereby authorize and direct The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release to government agencies, insurance carriers, managed care companies or others who are financially liable for my hospitalization and medical care and their authorized agents all information needed to substantiate payment for this hospitalization and medical care and to permit representatives thereof to examine and request copies of records to this care and treatment. This authorization includes information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV-related test, HIV infection, HIV related illness, AIDS or any information which would indicate potential exposure to HIV and any information related to or regarding genetic testing. I further authorize the Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release billing information to any provider involved in my care.

***Assignment of Insurance Benefits*:** I hereby assign and transfer to The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus, and Bassett Medical Group sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependent.

X _____ _____ _____

Signature of Parent/Guardian | Date | Time

ENROLLMENT SBHC

Student's Legal Name: DOB:

Dental Enrollment

Please check all that apply:

☐ No SBHC dental services are requested at this time. My child receives **yearly** dental care.

☐ Yes I would like my child to receive preventative and diagnostic dental care at SBHC.

Date of last dental cleaning/exam/x-rays: MM _____ DD _____ YR _____ need to be 6 months apart for insurance purposes

Dentist Name/Address/Phone: _____

Allergies: _____

If Yes, please sign below:

I give permission for School-Based Health to evaluate my child's teeth at school and if appropriate, provide preventative and diagnostic dental services (cleanings, x-rays and teledental exam, fluoride treatment, sealants).

Parent/Guardian Signature: _____ **Date:** _____

If you would like to be present for the dental visit please call your SBHC or 1-844-255-7242

DENTAL INSURANCE

Dental insurance coverage varies. Most plans will allow for only one cleaning (prophylaxis) and exam **every six months.** Please become familiar with your child's dental insurance coverage in order to avoid confusion with benefit payments.

Please copy both sides of insurance card and send with this form.

☐ We **do not** have **dental** insurance

Insurance Company: _____ Is this Child Health Plus ☐ Yes ☐ No

Phone # of Company: _____ Effective Date: _____

Insurance Co. Address: _____

_____

Subscriber ID #: _____ Group #: _____

If there is a two digit # next to student's name please provide after ID # _____

Legal Name of Policy Holder: _____ Date of Birth ____/____/_____

Social Security # of Policy Holder ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Policy Holder's Mailing Address: _____

_____ Phone # _____

Employer of Policy Holder: _____ Policy Holder's Relationship to child: _____

Does your child have more than one Health Insurance Plan? ☐ Yes ☐ No (If yes please copy card or contact SBHC)

Medicaid ID# ☐☐ ☐☐☐☐☐☐☐☐ Access # _____ Seq# _____

ENROLLMENT SBHC

MR # DOB

BASSETT HEALTHCARE NETWORK

NAME

DATE

INFORMED CONSENT FOR SCHOOL-BASED HEALTH CENTER TELEHEALTH SERVICES

H-10797 7/19;12/19 (d:\forms\hosp\.ofm)

Health Center _____

1. I understand that telehealth is the use of electronic information and communication technology to deliver health care services including, but not limited to, the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient, when the patient is located at a different site than the provider.
2. I understand that my child's School-Based Health Center health care provider wishes me to engage in a telehealth consultation or care for medical care, dietary counseling, psychiatric care or consultation with pediatric specialist.
3. My child's School-Based Health Center health care provider has explained to me how the electronic information and communication technology will be used during the consultation and that it will not be the same as a direct patient/health care provider visit since my child will not be in the same room with the health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties that may lead to an inability to obtain information sufficient for decision making about my child's health problem and that all reasonable precautions will be taken to minimize these risks. I understand that my child's health care provider or my child or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had the alternatives to a telehealth consultation explained to me. In choosing to participate in a telehealth consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. I understand that my child's healthcare information may be shared with other individuals for treatment, payment or operations purposes, in accordance with New York State and Federal Privacy rules and the Notice of Privacy Practices. Others may also be present during the consultation besides my health care provider, and consulting health care provider, in order to operate the communication equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that my child will be informed of their presence during the consultation and will have the right to request the following:
    a. omit specific details of their medical history/physical examination that are personally sensitive to them,
    b. ask non-medical personnel to leave the telehealth examination room, and/or
    c. terminate the consultation at any time.
7. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.
8. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my child's care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Bassett Department of Health Information Management at 607-547-3770.
9. I understand that my child has the right to have appropriately trained staff immediately available while receiving the telehealth service to attend to any emergencies and other needs.
10. I understand that I have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

By signing this form, I certify:

a. That I have read or had this form read and/or had this form explained to me,
b. That I fully understand its contents including the risks and benefits of the procedure(s), and
c. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient/Guardian _____ Date _____
(or person authorized to sign for patient)

If authorized signer, relationship to patient _____

CONSENTS

Bassett Healthcare Network

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). • We'll provide one accounting per year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by calling 1-800-BASSETT (1-800-227-7388) and asking for the Privacy Office. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

You can tell us your choices about what we share in certain circumstances. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your name and room number in our hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Sale of your information • Marketing purposes • Most sharing of psychotherapy notes requires specific release requirements
In the case of fundraising:	We may contact you for fundraising efforts, but you can tell us not to contact you again.
Patient Experience Surveys:	We want to understand and learn from your experience at Bassett, and your feedback is important. We may send a survey either by mail, email, or phone by our survey vendor. Your input helps us to understand what we are doing well, and what we can improve for you and future patients.
Research Studies	We may use portions of your medical information for research purposes. For example, determine if you qualify to enter a clinical trial for a new medication or treatment. You may request to be excluded.
Health Information Exchange of NY-HIXNY	Bassett Healthcare Network participates in the health information exchange of NY. You must authorize us to include your information.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.		
Treat you	• We can use your health information for treatment purposes and share it with other professionals who are treating you and for care coordination.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information for payment purposes, including to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?	
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**	
Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

As required by law, Bassett Healthcare Network will 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.**

MyBassett Health Connection Patient Portal

Bassett Healthcare Network offers the MyBassett Health Connection patient portal, through which you may:

- Communicate with your provider's office
- Access your test results
- Request prescription renewals
- Make appointments
- Request your medical records

Changes to the Terms of This Notice

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.

Effective: May [21], 2021

This Notice of Privacy Practices applies to all Bassett Healthcare Network participants including Bassett Medical Center, AO Fox Memorial Hospital, Little Falls Hospital, Cobleskill Regional Hospital, O'Connor Hospital and all network clinic locations. This Notice covers the organizations described above that are using this combined Notice of Privacy Practices and sharing information as provided by applicable law; they are not providing health care services mutually or on each other's behalf. Each organization participating in this joint Notice is individually responsible for its own activities, including compliance with privacy laws, billing, and for the health care services it provides.

Please contact your Privacy Office with any questions, concerns or complaints by emailing privacy@bassett.org or calling:

Facility	Phone
A.O. Fox Hospital **A.O. Fox Hospital Tri-Town Campus**	607-432-2000 or 607-431-5441
Bassett Medical Center	1-800-BASSETT or 607-547-7900
Cobleskill Regional Hospital	518-254-3456
Little Falls Hospital	315-823-5362
O'Connor Hospital	607-746-0310
Valley Health Services	315-363-6000 ext. 2900 or 315-363-6000 ext. 2282

Bassett Healthcare Network

* 2 6 1 0 *

AFFIX PT LABEL

I acknowledge receipt of the Bassett Healthcare Network Notice of Privacy Practices:

Name (Print):_____

Date of Birth:_____

Address:_____

City, State, Zip:_____

Signature:_____

Please clip and mail to: Privacy Office • Bassett Healthcare Network • One Atwell Road • Cooperstown, NY 13326

MR # DOB

NAME

* 3 4 9 7 *

BASSETT HEALTHCARE NETWORK
SCHOOL-BASED HEALTH CENTER

INITIAL HEALTH/DENTAL HISTORY

H-3497 12/02;3/04;3/06;4/08;10/08;9/15;10/16;5/18;11/19 (d:\forms\hosp\.ofm)

DATE

SBHC: _____

Child's Name: _____ Date of Birth: _____

Existing Medical Diagnoses (if applicable): _____

Do you have any additional health concerns about your child (dental, emotional, physical)? ☐ Yes ☐ No If Yes, please explain: _____

_____

Does your child have any allergies (food, medication, environmental, latex, pine nuts)?

Allergy: _____ **Reaction:** _____

_____

_____

Current medications (include vitamins, fluoride, supplements)

1. _____
2. _____
3. _____
4. _____

Please list any specialist your child sees (Physician Specialist, Counselor or Speech, Physical or Occupational Therapist)

_____

_____

_____

Name /address of primary care provider: _____

Date of last physical examination: _____ By whom: _____

List hospitalizations, serious illnesses, accidents, broken bones, surgeries, etc.

Date	Child's Age	Details

Social History: Do you have any concerns (behavioral, emotional, or otherwise) about this child? If yes please elaborate.

_____

_____

_____

Where does your child go after school? _____

What does your child do in his/her spare time (hobbies/sports)? _____

How many hours a day does your child watch TV/computer? _____

Indicate any financial, interpersonal, or family problems you are worried about: _____

_____

Any history of sexual/physical/emotional abuse? (Please describe) _____

_____

How is he/she doing in school? _____

Does he/she have good friends? _____

HEALTH MAINTENANCE SBHC

CONTINUED ON BACK

Who else lives at your child's home?

	Name	Age	Healthy?
Mother			
Father			
Siblings			
Others			

Relationship	Name	Living? Y/N	No Known Problems	Alcohol Abuse	Arthritis	Asthma	Autism	Autoimmune Disorder	Clotting Disorder	Cancer	COPD	Depression	Diabetes	Drug abuse	Heart disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Inflammatory Bowel Disease	Psoriasis	Thyroid Disease	Multiple Sclerosis	Other
Mother																									
Father																									
Sibling (1)																									
Sibling (2)																									
Sibling (3)																									
Sibling (4)																									
Mat. Gma																									
Mat. Gpa																									
Pat. Gma																									
Pat. Gpa																									
Cousin																									
Aunt																									
Uncle																									
Other																									

Mat. Gma = Maternal Grandmother
Mat. Gpa = Maternal Grandfather
Pat. Gma = Paternal Grandmother
Pat. Gpa = Paternal Grandfather

Bassett Healthcare Network School-Based Health

Patient Self-Reporting Survey

1. Patient Language

Please indicate your preferred language (i.e. English)

_____

Do you need an interpreter? _____ Yes _____ No

2. Ethnicity – Please check one

- o Costa Rican
- o Cuban
- o Dominican
- o Guatemalan
- o Honduran
- o Mexican, Mexican American, Chicano/a
- o Nicaraguan
- o Not of Spanish/Hispanic Origin
- o Panamanian
- o Patient Refused
- o Puerto Rican
- o Salvadoran
- o South American
- o Spaniard
- o Unknown

Turn Page Over ⟶

Race – Please check one

- o American Indian and Alaska Native
- o Asian
- o Asian Indian
- o Bangladeshi
- o Bhutanese
- o Black or African American
- o Burmese
- o Cambodian
- o Carolinian
- o Chamorro
- o Chinese
- o Chuukese
- o Declined to Report
- o Fijian
- o Filipino
- o Guamanian or Chamorro
- o Hmong
- o Indonesian
- o Iwo Jiman
- o Japanese
- o Kiribati
- o Korean
- o Kosraean
- o Laotian
- o Madagascar
- o Malaysian
- o Maldivian
- o Marina Islander
- o Melanesian
- o Micronesian
- o Native Hawaiian Native Hawaiian or Other Pacific Islander
- o Nepalese
- o Melanesian
- o Micronesian
- o Native Hawaiian
- o Native Hawaiian or Other Pacific Islander
- o Nepalese
- o New Hebrides
- o Okinawan
- o Other
- o Other Pacific Islander
- o Pakistani
- o Palauan
- o Papua New Guinean
- o Patient Refused
- o Pohnpeian
- o Polynesian
- o Saipanese
- o Samoan
- o Singaporean
- o Solomon Islander
- o Sri Lankan
- o Tahitian
- o Taiwanese
- o Thai
- o Tokelauan
- o Tongan
- o Unknown
- o Vietnamese
- o White or Caucasian
- o Yapese

Turn Page Over ⟶