HUMAN SERVICES COUNCIL

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Welcome to the Program

Effective: August 1, 2018

Dear Parent/ Guardian

Welcome to the Dr. Robert E. Appleby School Based Health Centers, a program of the Human Services Council. As a student in one of Norwalk's High Schools or Middle Schools with an onsite health center, your child has the opportunity to take advantage of our physical and/or mental health services. Our goal is to keep students healthy, in the classroom, and ready to learn.

Why use the School Based Health Center?

We provide easy access to high-quality physical and mental health-care, in a friendly setting, at a time that is convenient, at no out-of-pocket cost to your family. Our providers include board certified pediatricians, Nurse practitioners (APRN) and an Adolescent Psychiatrist leads a team of Licensed Mental Health Counselors. Students and parents are part of the team and our parent liaison and outreach staff will partner with you to get connected to the care you need.

There is no requirement to transfer care from your primary care provider (PCP)

What Service we Provide

- Diagnosis/Treatment of Acute & Chronic Illnesses
- Comprehensive Physicals
- Immunizations
- Health Screenings
- Basic Laboratory Tests
- Health Education & Health Counseling
- Individual, Group and Family Counseling
- Crisis Intervention
- Support with School & Life Transitions
- Support with Social Skills
- Support with Emotional Health Issues
- ADHD/ADD
- Crisis Intervention
- Anger Management
- Alcohol & Substance Abuse Prevention
- Anxiety/Stress Management
- Reproductive Health Issues: Screenings, Treatment, Prescribing
- Weight Management and Nutrition Counseling
- Referral and follow-up to medical Specialists, Community Providers, Agencies, and Hospitals
- Prescriptions, Medication Management (including psychiatric medications)
- Psychotherapy, Psychiatric, and Medication Assessment

How do you Participate ?

Complete and sign both the attached Consent Form and Medical History Form. Return the forms to the School Based Health Center at your child's school. If you carry health insurance, include a copy of your insurance card. If you do not have health insurance or your health insurance does not cover our services, there will be no charge to you.

If you have any questions, contact our Program Director, Ellen Carroll, at HSC 203-354-1952.

We look forward to working with you and your child. Healthy students make better learners.

Notice of Privacy Policy

HSC's Dr. Robert E. Appleby School Based Health Centers are required by law to protect certain aspects of your health- care information known as Protected Health Information (PHI) and to provide you with this Notice of Privacy Practices.

We respect your privacy, and treat all our patients' healthcare information with care, under strict policies of confidentiality that our staff are committed to following at all times.

The following page describes your legal rights, advises you of our privacy practices, and lets you know how HSC–SBHC is permitted to use and disclose PHI about you.

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Notice of Privacy Policy (cont'd)

We use and disclose PHI in many ways:

- **For treatment.** This includes such things as verbal and written information that we obtain about you and use pertaining to medical conditions and treatment provided by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment). We also may share PHI in order to coordinate the different services you need: prescriptions, lab work and diagnostic testing. We also may disclose PHI to people who may be involved in your medical care such as family members, etc.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the SBHC may be billed for and payment may be collected on your behalf from an insurance company or third party.
- **For Health Care Operations.**This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI without Your Authorization

HSC–SBHC is permitted to use PHI without your written authorization, or opportunity to object in certain situations including:

- For HSC-SBHC's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your insurance company);
- To another health care provider (such as the hospital to which you are transported) for the health care operations activities of the covered entity that received the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or when required to do so by federal, state ,or local law;
- To avert a serious threat to health or safety.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to inspect and copy medical and billing records**. This does not include psychotherapy notes. To inspect and copy medical information you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. HSC will provide you with a written denial; specifying the legal basis for the denial, a statement of your rights and a description of how you may file a complaint with us.
- **Right to Amend.** You have the right to request an amendment of your PHI for as long as the designated record is maintained by HSC. Your request must be in writing, providing the reason that supports your request. We may deny the request if you ask us to amend information not created by us; is not part of the medical information kept by or for the SBHC; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. This request must be submitted in writing to the Administrator including time period requested.
- **Right to Request Restrictions.** You have the right to request in writing, a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. This includes a limit on the medical information we disclose about you to someone who is involved in your care or the payment. of your care, like a family member.
- **Right to Request Confidential Communication.** You have the right to request, in writing that we communicate with you about medical matters in a certain way or at a certain location. Your request must include how and where you wish to be contacted. If you do not tell us how or where you wish to be contacted, wed do not have to follow your request.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right to Breach Notification.** You have the right to be notified of any breach of your unsecured information healthcare.

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Other Uses of Medical Information

For all other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization. If you provide permission to us to disclose PHI about you, you may revoke that permission, in writing at any time.

Complaints

If you believe your privacy rights have been violated, you may submit your complaint in writing to HSC:

Ellen Carroll, Program Director
Dr. Robert E Appleby School Based Health Centers
Human Service Council, One Park Street, Norwalk CT 06851

Changes To This Notice

We reserve the right to amend or revise this Notice at any time. The revised or amended Notice may be made effective for all PHI HSC maintains as well as any information we received in the future. We will post a copy of the current notice in our office which will contain the effective date.

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Enrollment Form

Effective: August 1, 2018

Student's Name

_____ Sex: M ___ F ___ D.O.B. _____
Last First Middle

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Home Phone Cell Phone Work Phone

Who lives with student? Mother ___ Father ___ Siblings (#) ___ Other (explain) _____ Total # of people living in household

Grade _____

___ Norwalk HS
___ Nathan Hale MS
___ Brien McMahon HS
___ Ponus Ridge MS
___ West Rocks MS

Please complete all information on the front and back of this registration form. You must sign and date it in order for your student to receive services from the School Based Health Centers. If a student is 18 or older, he/she can sign his/her own registration form.

Race of student (Per Federal OMB Guidelines):

_____ Amer Indian/Alaskan Native
_____ White
_____ Asian
_____ Black/African Descent
_____ Native Hawaiian or other Pacific Islander

Ethnicity of student (Per Federal OMB Guidelines):

_____ Hispanic/Latino(a)
_____ Non Hispanic/Non Latino(a)

other, kindly write in here: _____

Who is your child's doctor/clinic: _____ _____
Phone

Where do you usually bring your student for medical care?

___ Community Health Center
___ Emergency Room
___ Health Department Clinic
___ Hospital Clinic/Outpatient
___ Military Clinic
___ Private MD
___ School Based Health Clinic
___ Urgent Care Clinic
___ Mobile Van
___ None
___ Other

Please indicate your relationship to student: Guardian ___ **Other** _____

Does your child receive free or reduced-price lunch ___ **Yes** ___ **No**

Contact

_____ _____ _____
Parent or Guardian Name: Phone Relationship

_____ _____ _____
Emergency Contactt (if different than above) Phone Relationship

Does your child have Insurance / Medicaid ___ **Yes** ___ **No** **Medicaid#** _____

Carrier Name _____ **Group #** _____ **Policy #** _____

Policy Holder Name _____ **Policy Holder D.O.B.** _____ **Effective Date of Coverage** _____

Permission Form

I give permission for the student identified in this application to obtain services at the Dr. Robert E. Appleby School Based Health Centers, (REASBHC) while they are in school. The permission will remain in effect throughout the time my student is attending Norwalk Public Schools, unless I withdraw it.

_____ **M** ___ **F** ___ _____
Student Name (Print) **Date of Birth**

My signature below indicates that I have read the information packet describing the services of the Schoool Based Health Centers (SBHC) and have received the Notice of Privacy policy (attached). I hereby give permission for the above named student to obtain services offered at the SBHC while they are in school. I give permission for the exchange of relevant health and safety information between the SBHC and appropriate school staff involved in the overall care of the named student within the confines and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the attached Privacy Notice and the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C.1232g; 34 CFR Part 99). The goal of this process will be to assist in maintaining health and safety in schools and to coordinate my child's care. In the event the student is referred to Norwalk Hospital for evaluation and/or treatment, I give permission to Norwalk Hospital staff to release related treatment information to the Dr. Robert E. Appleby School Based Health Centers. Furthermore, I give permission to the SBHC to release information regarding treatment and/or services (medical and/or behavioral health services) to the named insurance providers for the purpose of billing. I authorize payment to be made directly to Human Services Coucil for services provided.

_____ _____
Parent/Guardian/Other Signature **Date**

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FOR OFFICE USE ONLY

SBHC Chart # _____ Date Opened (first Visit) _____

Student Name _____ D.O.B _____

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Medical History

If you circle "Yes" to any of the questions below, please list or explain:

Is your child taking any medications? N ☐ Y ☐ _____

Does your child have any allergies to food? N ☐ Y ☐ _____

Does your child have any allergies to drugs? N ☐ Y ☐ _____

Does your child have any allergies to environmental factors? N ☐ Y ☐ _____

Does your child have any allergies to latex? N ☐ Y ☐ _____

Does your child have any other allergies? N ☐ Y ☐ _____

Has your child ever been hospitalized/had surgery/been injured? N ☐ Y ☐ _____

Date of last Dental Visit ____ /____ /____ Dentist Name _____

Does you child have (or had) any of the following?

Y	N		Y	N		Y	N	
☐	☐	Alcohol / Drug Problems	☐	☐	Heart Problems / Murmur	☐	☐	Pregnancy
☐	☐	Arthiritis	☐	☐	Hepatatis / Liver Disease	☐	☐	Prosthetics
☐	☐	Asthma / Reactive Airway	☐	☐	Hernia / Undescended Testicle	☐	☐	Rheumatic Heart Disease
☐	☐	Attention Deficit Disorder	☐	☐	High Blood Pressure	☐	☐	Scoliosis, Knee Injury
☐	☐	Blood Disorders (Anemia)	☐	☐	High Cholesterol / Triglycerides	☐	☐	Seizures
☐	☐	Broken Bones	☐	☐	Immune Deficiency Disorders	☐	☐	Sickle Cell Trait or Disease
☐	☐	Cancer	☐	☐	Measles	☐	☐	Skin Disorders
☐	☐	Chicken Pox	☐	☐	Meningitis	☐	☐	Sleeping Problems
☐	☐	Concussions	☐	☐	Menstrual Problems	☐	☐	Stomach / Bowel Problems
☐	☐	Depression / Anxiety	☐	☐	Mental Health Concerns	☐	☐	Thyroid Problems
☐	☐	Diabetes, Endocrine Disorder	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	Ear Infections	☐	☐	Mumps	☐	☐	Urinary Tract Infections
☐	☐	Headaches / Fainting	☐	☐	Organ Removal / Transplant	☐	☐	Weight or Eating Problems
☐	☐	Hearing Problems	☐	☐	Pneumonia			

Please list any concerns you have regarding your child's health:

Family History

Please check below if any of your child's realatives (i.e. parents, brothers/sisters, aunts, uncles and grandparents) have/had any of the following illnesses and note which relative on the lines below:

Illness	Relative	Illness	Relative
☐ Alcohol / Drug Problems	_____	☐ High Blood Pressure	_____
☐ Blood Disorders (Anemia)	_____	☐ Infections (TB/HIV/AIDS)	_____
☐ Cancer	_____	☐ Liver / Kidney Problems	_____
☐ Death under the age of 50	_____	☐ Mental Illness / Emotional Problems	_____
☐ Diabetes, Endocrine Disorder	_____	☐ Respiratory Problems / Asthma	_____
☐ Eczema	_____	☐ Sickle Cell Trait or Disease	_____
☐ Heart / Vascular Disease / Stroke	_____	☐ Seizures	_____