



**SCHOOL BASED**  
Health & Wellness Centers

Patient/Grade: \_\_\_\_\_

Date Received: \_\_\_\_\_

Existing NCHC Patient? \_\_\_\_\_

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender at birth:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

NPS School:  Ponus  CMS  McMahon  CGS  Kendall  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PERMISSION FOR SERVICES**

I consent to the following services for my child:

- Medical Services  Immunizations
- Mental Health Services  Physical Exams (Sports/Employment)

**INSURANCE INFORMATION**

- No Insurance (need to apply for sliding scale)
- Primary Insurance

Name of Insurance Company: \_\_\_\_\_ State: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Relationship to Insurance holder:  Self  Parent  Child  Spouse  Other \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date



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**CONSENT**

School-Based Health & Wellness Center. Designated School-Based Health Center team members are obligated by law to disclose specific patient information to DPH, for the purpose of preventing or controlling disease, injury, surveillance, or disability in Connecticut as well as in the United States. Such information mandated and required by law includes: sexually transmitted disease; laboratory data; births; deaths; adverse medication reactions; child abuse or neglect; and domestic violence. Other general information will also be sent to DPH for statistical tracking, but this information will be de-identified which means that my student's name will be removed.

I have had the opportunity to receive and review the Norwalk Community Health Center Notice of Privacy Practices.

I understand that the School-Based Health & Wellness Center may use telemedicine to provide behavioral health and medical services. The video conference between student and provider does not involve data storage, recording, or archiving. Telemedicine encounters would still be subject to the requirements of the HIPAA Privacy Rule that applies to Protected Health Information.

I understand that insurance may be billed for covered services and the need to provide insurance information before services are provided.

I understand in accordance with HIPAA & FERPA I consent to the school nurse, social worker, and/or psychologist communicating directly with the HWC staff for continuity of care and the HWC staff communicating with the school nurse, social worker and/or psychologist directly.

I understand that the Health & Wellness center shall not charge co-pays or any other out-of-pocket fees for use of School-Based Health Center Services.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the School-Based Health Center associated with my student's care.

I understand if I have an outside Primary Care Provider I consent to release of information directly to my Primary Care Provider for continuity of care and will list their name on the Patient Registration Form.

I acknowledge that all information requested on the registration Health History Form and this consent is accurate and complete. My student and I have read this form carefully and I understand that if I have any questions I may call the School-Based Health Center Coordinator for any explanation(s) before I sign this authorization.

By my signature below I certify, as the parent or legal guardian of the student named above, I understand the School-Based Health Center consent for treatment. This consent is valid for duration of my child's years in the Norwalk Public Schools.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Student

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

Ponus/CMS SBHC  
21 Hunters Lane  
Norwalk, CT 06850  
p. 203-899-2208  
f. 888-571-5871

McMahon/CGS SBHC  
300 Highland Avenue  
Norwalk, CT 06854  
p. 203-854-0524  
f. 888-571-1744

Kendall SBHC  
57 Fallow Street  
Norwalk, CT 06850  
p.  
f.

Family Center  
1 Park Street  
Norwalk, CT 06851  
p.  
f.



**HEALTH HISTORY FORM**

Does your child have any allergies?  No  Yes: \_\_\_\_\_

Does your child have any chronic medical conditions i.e. asthma, migraines, depression? \_\_\_\_\_

Please provide the following information about medicines your child is taking

Name of medicines:	Reason taken:	How long taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been hospitalized overnight?

Yes  No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

Has your child ever had any serious injuries/illness?

Yes  No If yes, please explain. \_\_\_\_\_

Has your child been seen in an emergency room within the last year?

Yes  No If yes, please indicate the number of visits: \_\_\_\_\_

Reason(s) for visit(s): \_\_\_\_\_

Has your child been seen for a dental visit in the last year?

Yes  No Name of Dentist: \_\_\_\_\_

Has your child ever been hospitalized or received counseling for emotional health?

Yes  No If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

Reason: \_\_\_\_\_

In the past year, have there been any changes in your family such as:

- Marriage  Serious Illness  Change in school  Births  Divorce  
 Separation  Loss of Job  Move to a new house  Deaths  Other

**PARENT OR LEGAL GUARDIAN CONCERNS**

*Below are some common concerns of adolescents and families. If you have any of these concerns, please encourage your child to schedule a visit at the Wellness Center or you can feel free to call the Wellness Center to discuss your concerns.*

Weight/Diet/nutrition

Sleep Patterns

Smoking cigarettes/chewing tobacco

Choice of friends

Self image/self worth

Depression

Lying, Stealing, or vandalism

Violence

School grades truancy/dropout

Relationships with family members

Drug/Alcohol use

Sexual behaviors

Sexual identity

Excessive moodiness or rebellion



**HIPAA NOTICE OF PRIVACY PRACTICES**

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

**We may use or disclose your protected health information in the following situations without your authorization:** as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

**We will not retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerns or objections to this form, please ask to speak with our Director of Quality, Risk & Compliance.

**Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you.** No medical information is provided.

necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

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