APPALACHIAN MOUNTAIN
COMMUNITY HEALTH CENTERS

School-Based Health Center
Permission to Treat

Dear Parent/Guardian:

Appalachian Mountain Community Health Centers (AMCHC) has a fully functioning health center on campus where a licensed nurse practitioner, dentist, and licensed clinical social worker provide quality healthcare. Services include primary care (wellness exams, sick exams, physical exams, vaccinations, acute care, etc.), behavioral health (psychotherapy/counseling, medication management), and dental services (dental cleaning and exams). AMCHC school-based health center is prepared to become your student's medical home or supplement existing primary care.

If you should have any questions, please call AMCHC School-Based Health Center at:

- Asheville High School 828-676-3593
- Peak Academy 828-253-3717

Health history information must be filled out before any services will be given.

Name of Student: _____ Date of Birth: _____ Grade: _____

Sex: Male ☐ Female ☐ Other ☐ (Specify)_____

Race: _____ SSN: _____ Primary Language: _____

Parent/Guardian:_____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address: _____

Student's Healthcare Provider: _____ Phone: _____

Does your child have health insurance? ☐No ☐ Yes

Medical Insurance Name: _____ Group #: _____ Policy #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relation to Patient: _____ Subscriber SSN: _____

Dental Insurance Name: _____ Group #: _____ Policy #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relation to Patient: _____ Subscriber SSN: _____

Please list any medications your child is allergic to: _____

☐No ☐Yes **Glasses/contacts**, Date/Place of last eye exam: _____

☐No ☐ Yes **Hearing aids**, Date/Place of last hearing exam: _____

☐No ☐ Yes **Dental Problems**, Date/Place of last dental exam: _____

Please list any medications your child is on, including dosage and strength:

_____

_____

_____

Dental History

Former Dentist: _____Phone: _____

Date of Last Dental Visit: _____Date of Last X-Rays: _____

Check if you have any of the following:

☐ No ☐ Yes **Bad Breath** ☐ No ☐ Yes **Grinding/Clenching teeth** ☐ No ☐ Yes **Sensitivity to Heat**

☐No ☐Yes **Bleeding Gums** ☐ No ☐ Yes **Loose Teeth or Broken Fillings**

☐No ☐ Yes **Sensitivity to Sweets**

☐ No ☐ Yes **Clicking or Popping Jaw** ☐ No ☐ Yes **Periodontal Treatment**

☐ No ☐ Yes **Painful Biting/Chewing** ☐ No ☐ Yes **Food Wedging Between Teeth**

☐ No ☐ Yes **Sensitivity to Cold** ☐ No ☐ Yes **Sores of Growths in Mouth**

How Often Do You Brush: _____ How Often Do You Floss: _____

Other Information

When was the last time the student was seen by a doctor?

Doctors Name: _____Reason: _____ Date: _____

Do you have concerns about Student's health? ☐ No ☐Yes

Does the Student drink alcohol? ☐ No ☐Yes

Does the Student smoke and/or use tobacco products? ☐ No ☐Yes

Is the student exposed to secondhand smoke? ☐ No ☐Yes

Immunization Status

Is the Student up to date on immunizations? ☐ No ☐ Yes

Family Income

People in Household: _____ Annual Family Income $_____

Does the student qualify for free or reduced lunch? ☐ No ☐ Yes

Appalachian Mountain Community Health Center
School-Based Health Center

Assignment of Benefits/ Consent for Treatment

I consent to the customary test, minor surgical procedures, and procedures that may be deemed necessary for the treatment of my child's condition by members of the Medical, Dental, and Behavioral Health Staff of Appalachian Mountain Community Health Centers. Consent is hereby given for such visits to the school health center, dental unit, and behavioral health for examination, treatment, and procedures for this claim. I also request payment of government benefits to the party who accepts the assignment. I authorize payment of medical, dental, and behavioral health benefits to the supplier for services provided by AMCHC. I understand that I may be billed separately for services provided by clinic providers for treatment-related services.

Authorize for Release of Medical, Dental, and Behavioral Health Information

I hereby authorize the release of medical, dental, and behavioral health information as necessary for the settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol, or drug abuse, and HIV-related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, dental, and behavioral health records, as well as the release of records to my child's primary care provider. Further, I release AMCHC and any related corporations or affiliates from any liability resulting from the release of medical information regarding the sexually transmitted disease, if applicable, to Third Party Payor according to KRS 214.420

I have read the above and understand the items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and a Bill of Rights.

I hereby permit AMCHC to verify the above information and for the student's health care provider (as listed on this form) to release required medical records (immunization records, preventative health care exams, dental exams, behavioral health, vision exams, etc.) to AMCHC.

This form will be valid until revoked.

I approve my child to be seen for the following (**selecting "all services" in all categories maximizes access to care and does not require participation in this service):**

School-Based Health Center	**Behavioral Health**	**Dental Mobile Van**
☐ **All Services** (most common response)	☐ **All Services (**most common response)	☐ **All Services (**most common response)
☐ Limited services including:	☐ Limited services including:	☐ Limited services including:
☐ Wellness/Physical/Preventive Care	☐ One-on-one counseling	☐ Cleaning, including oral exam with x-rays
☐ Sick/Injury/Acute	☐ Group counseling	☐ Sealants
☐ Vaccines		☐ Topical Fluoride
☐ Chronic conditions (asthma, diabetes, etc.)		

Phone: _____ Parent/Guardian's Email: _____

_____ _____ _____

Parent/Guardian Name (Please Print) **Parent/Guardian Signature** **Date**

Student Phone: _____ Student's Email: _____

_____ _____ _____

Student Name (Please Print) **Student Signature** **Date**