Cy-Fair
COMMUNITY HEALTH CENTER
Healthy Families. Healthy Community.

CONSENT FOR TREATMENT

Name of Student	Date of Birth	Campus	Grade
_____	_____	_____	_____

I understand that Cy-Fair Community Health Center (Cy-Fair CHC) provides health services to students. One consent form per student must be signed and on file at Cy-Fair CHC for the student prior to receiving services. By marking **yes** I consent to the following:

Yes	No	
☐	☐	I consent for my child to receive **medical care*** at Cy-Fair CHC. *Examples but not limited to: treatment of minor illness, well child exams and physicals, vaccinations, chronic disease management, and health education.*
☐	☐	I consent for my child to receive **dental care** at Cy-Fair CHC. *Examples but not limited to: cleanings, x-rays, sealants, and fluoride application). Some treatments may be delivered by a dental hygienist or dental assistant.*
☐	☐	I consent for my child to receive **behavioral health services** at Cy-Fair CHC. *Examples but not limited to: evaluation, diagnosis, and treatment.*
☐	☐	I consent for my child to be transported by CFISD Transportation to and from appointments at Cy-Fair CHC during school day. Students will only be released to parents/guardians from the student's home campus. *Transportation will be provided at these schools:* **Hopper M.S.**, **Kahla M.S.**, **Thornton M.S.**, **Cy-Lakes H.S.**, **Cy-Park H.S.**, **& Cy-Springs H.S.** Please indicate any special requirements or accommodations (*i.e.* wheelchair): _____

**Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian.*

I understand that my insurance company, if I have coverage, will be billed for services rendered at Cy-Fair CHC. I hereby authorize the Cy-Fair CHC staff to release medical records and information required by the insurer to obtain payment. I understand that I am responsible for all costs of treatment to include any services not covered by my insurance benefits.

Due to the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations, Cy-Fair CHC staff will use and share my child's Protected Health Information (as that term is defined in HIPAA) for: *1)* purposes related to the treating my child; *2)* payment for services provided to my child; and *3)* routine Cy-Fair CHC operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that the Notice of Privacy Practices document is available at the location(s) where my child receives his/her health care services and on the Cy-Fair Community Health Center website at www.sbchc.net

By signing below, I confirm I am the parent/legal guardian of the above named student and am authorized to give this consent. This consent is effective for up to one year from the date below unless earlier revoked.

_____ _____

Parent/Guardian Signature Date

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PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Last Name:	First:	Middle:	Alternative Names (if any):		
Home Address:		Apt/Suite:	City:	State:	ZIP Code:
Gender at Birth: ❑M ❑F	Birth Date: / /	Email Address:	Phone Number: ( )		Marital Status: ❑Single ❑Married ❑Divorced ❑Other

Patients 18 years old and up, answer the following questions:

Sexual Orientation[1]:	Current Gender Identity[2]:
❑Straight ❑Lesbian/Gay ❑Bisexual ❑Don't know ❑Something else ❑Choose not to disclose	❑Male ❑Female ❑Choose not to disclose ❑Other ❑Transgender F (M-to-F) ❑Transgender M (F-to-M)

Preferred Language: ❑ English ❑Spanish ❑Other:_____	Are you a veteran of the U.S. Armed Forces? ❑Yes ❑No	Are you currently homeless? ❑Yes ❑No
Race: ❑White ❑Asian ❑African American ❑Pacific Islander ❑American Indian ❑More than one race ❑Other: _____		Latino/Hispanic Descent: ❑Yes ❑No
Household Income: $ _____	Household Size: _____ (number of people living in the same house as you)	

Chose clinic because/referred to clinic by (please check one box):

❑ Relative/Friend ❑ School ❑ Hospital ❑ Church ❑ TV ❑ Direct Mail/Flyer ❑ Health Fair
❑ Internet ❑ Magazine ❑Newspaper ❑ Radio ❑ 211 ❑ Other: _____

EMERGENCY CONTACT

Name:	Relationship to Patient:	Address:	Phone Number: ( )

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No (If you checked 'No', please skip this section)			
Please indicate primary insurance:	❑ Medicaid ❑ Medicare ❑ CHIP ❑ CHIP Perinatal ❑ Private Insurance:_____ ❑ Other:_____		
Person responsible for charges:	Birth Date: / /	Address (if different from above):	Home Phone Number: ( )
Group Name:	Group Number:	Policy Number:	Co-Payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____			
Dental Insurance:	Subscriber's Name:	Birth Date: / /	Group Number:	Policy Number:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____			

1: **Sexual orientation** is the term used to describe what gender(s) someone is sexually and/or romantically attracted to.

2: **Gender identity** is how we feel about and express our gender and gender roles — clothing, behavior, and personal appearance. It is a feeling that we have as early as age two or three.

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PARENT/GUARDIAN INFORMATION

Mother/Guardian Last Name: First: Middle:		Date of Birth: / /
Email Address:	Home Phone Number: ( )	Work Phone Number: ( )
Father/Guardian Last Name: First: Middle:		Date of Birth: / /
Email Address:	Home Phone Number: ( )	Work Phone Number: ( )
Parent/Guardian Address:		

STUDENT'S HEALTH STATUS

Child's Pediatrician *(if applicable)*:	Phone Number: ( )	Date of Last Physical Exam: / /
Child's Dentist *(if applicable)*:	Phone Number: ( )	Date of Last Physical Exam: / /
List of Child's allergies (*if any*). *Examples: medicines, foods, bee stings, latex, etc.*		
List of Child's current medications (*if any*):		
Special Diet:		
Is there any **important health information** we should know? *(Pregnancy, history of cancer/tumor/tuberculosis)*		
Has your child been hospitalized overnight in the past year? ☐ Yes ☐ No If yes, why?		
Has your child had any surgeries in the past year? ☐ Yes ☐ No If yes, describe		
Would you like to request any other assistance or do you have comments to help us serve you better?		

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STUDENT AND FAMILY HISTORY

This information helps us determine proper screening for the student

Disease	Student	Mother	Father	Sister(s)	Brother(s)	Grand Parents	Other Relative(s)	Comments
NONE								
Anemia								
Alcoholism/Drug Abuse								
Alzheimer's								
Artificial Heart Valve/Joints								
Asthma/Breathing Treatments								
Autoimmune Disease								
Bleeding or Clotting Disorder								
Cancer								
Coronary Artery Disease *(i.e. heart attack, angina)*								
Depression/Suicide/Anxiety								
Diabetes (childhood onset)								
Diabetes (adult onset)								
Genetic Disorder (explain)								
Glaucoma								
Heart Disease (CHF)								
Hepatitis B or C								
High Blood Pressure – Hypertension								
High Cholesterol								
Hypothyroidism/Thyroid Disease								
Kidney Disease								
Learning Disabilities/Special Education								
Lung Disease/Tuberculosis								
Macular Degeneration								
Migraine Headaches								
Osteoporosis								
Seizures/Epilepsy								
Other (list)								
Additional Information								