Peninsula Community Health Services

School-based Health Center (SBHC) -- REGISTRATION FORM

Last Name:			First Name:
Preferred Name:			Middle Name:
Date of Birth: / /	Sex at Birth: M / F		Patient Email:
Preferred Contact: ☐Home ☐Work ☐Mobile		How would you like to receive your after-visit summary? ☐Portal ☐Paper	
Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	Voice Message ok? ☐Yes ☐No Text Message ok? ☐Yes ☐No	
Who is your current/former Primary Care Provider (PCP):			

Guarantor Information (to whom statements are sent)		Emergency Contact Information
Name:		Name:
Relationship:		Relationship:
DOB:	Phone:	Home Phone:
Address:		Mobile Phone:

School and Student Information

Name of School:	Student ID:

UNIFORM DATA SYSTEMS-PCHS is required to collect the following information from our patients who utilize our services. The following information, when reported, does not include any personal identification information and is confidential.

Language? **Do you need an Interpreter?** ☐Yes ☐No

Ethnicity (check one): ☐Mexican, Mexican American, or Chicano(a) ☐Puerto Rican ☐Cuban ☐Another Hispanic, Latino(a), or Spanish origin ☐Not Hispanic/Latino(a) ☐Unreported/Refused

Race (check all that apply): ☐Asian Indian ☐Chinese ☐Filipino(a) ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐ Other Pacific Islander ☐Guamanian or Chamorro(a) ☐Samoan ☐Black/African American ☐American Indian/Alaskan Native ☐White ☐Unreported/Refused

Check range of your household's annual income: ☐$0 - $15,060 ☐$25,820.01 - $31,200 ☐$15,060.01 - $20,440 ☐$31,200.01 - $36,580 ☐$20,440.01 - $25,820 ☐$36,581 & Higher	**How many people are in your household:**
Questions below apply to 18yrs old and above* **Sexual Preference: (check)** ☐Straight/ Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Don't Know ☐Other, Please Describe:_____ ☐Choose not to disclose Preferred Pronouns:_____ **Do you think of yourself as: (check)** ☐Male ☐Female ☐Female-to-Male (FTM)/Transgender Male/Transman ☐Male-to-Female (MTF)/Transgender Female/ Transwoman ☐Gender non-conforming, neither exclusively Male nor Female ☐Other ☐Choose not to disclose	***Housing Information*** ☐own/rent your home without help (NOT HOMELESS) ☐ Staying with Friends /Relatives (DOUBLING UP) ☐Have concerns about your housing and want help(OTHER) ☐Living on the street, outdoor, in a car/travel trailer(STREET) ☐Staying in a treatment facility (TRANSITIONAL) ☐Living in public housing where all tenants get discount rent (PUBLIC HOUSING) ☐Staying in a shelter-short term housing like the mission, YMCA, etc (SHELTER) ☐Living Somewhere not meant to be a home-no running water/heat (OTHER) ☐Having been homeless in the last year and have housing now (TRANSITIONAL) ☐Homebound

Primary Insurance ☐ I have no insurance please contact me for options

Plan Name:
Last Name: (carrier's info) First Name: Middle Name:
ID# Group#
Address: City: State: Zip:
DOB: / / Sex: M / F Relationship to Patient:

Insurance Authorization

I accept financial responsibility for all my professional services and/or supplies. Payment for services is due at the time rendered unless arrangements have been made. I authorized my insurance to pay PCHS directly. I am financially responsible for any balance due. I authorize PCHS or the insurance company to release any information for claims unless specifically limited by me in writing.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

I acknowledge that I have received a copy of my rights and responsibilities. Initials _____

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HEALTH HISTORY QUESTIONNAIRE (PEDIATRICS)

NAME: First: _____ MI: _____ Last: _____

Birthdate (MM/DD/YYYY): ____ / ____ / _____ **Gender Identity:** M / F / Transgender (FTM or MTF) / _____

PRIOR / OUTSIDE CARE

Medical provider(s): _____ Recent ER / HOSPITAL? No | Yes Reason(s): _____

Dental provider(s): _____ _____

ALLERGIES		NAME	REACTION:
NONE ❒	❒ LATEX		
	❒ ANESTHESIA		

MEDICATIONS (Prescriptions, over-the-counter meds, supplements)

NAME	DOSE / STRENGTH	DIRECTIONS (AMOUNT / FREQUENCY)	REASON FOR USE

MEDICAL HISTORY (CIRCLE THOSE THAT APPLY TO THIS PATIENT)

Abdominal pain	Cancer	Headache / Migraine	Seizures / Epilepsy
ADD / ADHD	Congenital disorder	Heart disorder	Skin disorder (Acne, Eczema)
Allergies	Dental / tooth disorder	High Blood Pressure	Speech / language disorder
Anxiety	Depression	High Cholesterol	Thyroid disorder
Asthma	Development disorder	Immune disorder	Urinary disorder (UTI etc)
Back disorder	Diabetes	Kidney disorder	Weight concerns
Blood disorder	Ear (Hearing, infections)	Liver disorder	_____
Bowel disorder	Eye (Vision, movement)	Reflux / GERD / Ulcer	_____

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SOCIAL HISTORY (HELP US GET TO KNOW PATIENT BETTER!)

PLACE OF BIRTH: _____ TRAVEL OUTSIDE USA?: YES NO TB EXPOSURE/RISK: YES NO

WHO DOES PATIENT LIVE WITH? Mother | Father | Sibling | Relative | Friend | Foster Home | Other _____

(CIRCLE ALL THAT APPLY)

SIBLINGS: N/A NAME: _____ DOB _____; NAME: _____ DOB: _____

NAME: _____ DOB _____; NAME: _____ DOB: _____

HOME SITUATION: *(CIRCLE ALL THAT APPLY)* TOBACCO USE PETS GUN OR WEAPON Stored locked / ammo separate? YES | NO

SUBSTANCE USE: *(CIRCLE ALL THAT APPLY)* CAFFEINE TOBACCO ALCOHOL DRUGS

SURGICAL HISTORY (PATIENT)

PROCEDURE	YEAR	PROCEDURE	YEAR	GENDER-SPECIFIC	YEAR
❒ Abdomen / bowel (appendix, etc.)	____	❒ ENT (tonsils, ear tubes)	____	❒ Circumcision	____
❒ Back / Spine	____	❒ Eye	____		
❒ Brain / Head	____	❒ Hernia	____	❒ Other:	____
❒ Cardiac / Heart	____	❒ Other:	____		

FAMILY HISTORY (CIRCLE THOSE THAT APPLY TO FAMILY MEMBERS)

CONDITIONS	RELATIVE(S)	CONDITION	RELATIVE(S)	CONDITION	RELATIVE(S)
Alcohol / Substance Use		Family crisis / trauma		Reflux / GERD / Ulcer	
Allergies		Headache / Migraines		Seizures / Epilepsy	
Anemia		Hearing / ear disorder		Stroke / TIA	
Asthma		Heart disease (before 55y)		Thyroid disorder	
Blood disorder		High Blood pressure		Urinary disorder	
Cancer		High Cholesterol		Vision / eye disorder	
Dental / tooth disorder		Immune disorder		Weight concerns	
Depression		Kidney disease		Other / Notes:	
Developmental disorder		Liver Disease			
Diabetes		Mental Health disorder			

COMMENTS: (additional information we should know about PATIENT's history)

Peninsula Community Health Services

HEALTH INSURANCE PORTABLITY ACCOUNTABILITY ACT (HIPAA), PERSONAL HEALTH INFORMATION (PHI), AND HEALTH INFORMATION EXCHANGE (HIE)/COMMUNITY INFORMATION EXCHANGE (CIE)

Privacy Notice Acknowledgment

I acknowledge that I have received the Peninsula Community Health Services' Health Insurance Portability Accountability Act (HIPAA) pamphlet. I have been informed that any questions and/or comments about this notice can be directed to the Privacy Officer, Jennifer Kreidler-Moss, PharmD, CEO, at the following address and phone number:

Peninsula Community Health Services PO Box 960 Bremerton, WA 98337 (360) 377-3776

Notice of Privacy Practices

Peninsula Community Health Services (PCHS) maintains a record of your healthcare services. You may ask us to see a copy of that record. You may ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may request to see your record or get more information by contacting our Health Information Management Department at the following address and phone number:

Peninsula Community Health Services HIM Department PO Box 960 Bremerton, WA 98337 (360) 377-3776

Information Sharing

PCHS works in an integrated health system (i.e. medical, dental, pharmacy, mental health, substance use disorder, enabling/support services). For purposes of continuity and coordination of care, PCHS shares patient information within our own system of care. In order to better meet your healthcare needs, PCHS may also share patient information with community partners such as hospitals, schools, and jails to the extent allowed by law. Where patient privacy laws limit information sharing, PCHS will not share your information unless you give proper consent.

Consent to Participate in Health Information Exchange/Community Information Exchange

PCHS has agreed to participate in a Health Information Exchange (HIE) to share important elements of your care with other healthcare providers and Community Information Exchange (CIE) to coordinate community referrals unless you opt out of the HIE/CIE. Ultimately, participation leads to better, safer, more efficient care for you and your family.

_____ **NO to Participate** The named patient, or their representative, does not consent to the disclosure of the patient's protected health information to HIE and CIE to carry out routine treatment and healthcare operations for continuity of care.

By my signature below I hereby acknowledge that I have been made aware of the availability of the Privacy Notice Acknowledgement, Notice of Privacy Practices, and PCHS' participation in the Health Information Exchange and the Community Information Exchange.

_____ _____
Patient Signature Date

_____ _____
(Print) Guardian/Legal Representative Name Relationship to Patient

_____ _____
Guardian/Legal Representative Signature Date

03/29/2024
Operations

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Peninsula Community Health Services

CONSENT FOR HEALTHCARE SERVICES FOR MINORS

Peninsula Community Health Services' (PCHS) must have a signed consent from a parent or guardian before providing health care services to minors under the age of 18, except in situations where federal and/or state law allows minor patients to access and consent to treatment without parental/guardian consent.

_____ (initial) **I authorize**

_____ (initial) **I do NOT authorize**

Print Minor's Name: _____ DOB: _____
First Name, Middle Initial, Last Name

to receive healthcare services available from and deemed necessary or advisable by a PCHS provider. Healthcare services may include, but are not limited to: routine medical exams, sports physicals, well-child or well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, and photographs for medical charts. PCHS encourages family involvement in the care provided to minor patients. However, if I am unable to be present, I authorize the above-named minor patient to receive healthcare services in my absence. Consent is also given for referral of care and, if necessary, emergency transportation to other healthcare providers or agencies deemed necessary by PCHS providers. This consent does not allow services to be given without the minor patient's consent unless the minor patient is unable to consent.

_____ (initial) I consent to the minor patient receiving immunizations.

_____ (initial) I do NOT consent to the minor patient receiving immunizations.

I understand that I may be required to sign additional consents for some surgical procedures.

I understand that this consent may be revoked at any time by writing to PCHS.

I understand it is my responsibility to report any changes in the patient's medical, behavioral health, or dental history to PCHS. Unless changes are noted by me, the provider will assume that there have been no changes in the patient's medical history.

In accordance with federal and/or Washington State law, when consent is provided for care, health information is kept confidential except in the following circumstances:

- The patient permits release of information through a signed authorization.
- The patient exhibits a risk of imminent harm to self or others.
- The patient has a life-threatening health problem and is under 18 years old.
- There is reason to suspect abuse or neglect.

4/26/2022

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Peninsula Community Health Services
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• Certain communicable diseases must be reported to public health authorities.
• Other disclosures as required by law.

The following consent is for school-based health services only. If your child does not utilize school-based health services, skip to signature below.

_____ **(initial)** I authorize my child's school to release basic FERPA demographic information (name, date of birth, address, and phone number) to PCHS' school-based health program staff to allow for care coordination. An authorization for records release with a parent/guardian signature is required if records need to be released to my child's school.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Relationship to Minor	Phone number	

4/26/2022

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RELEASE OF VERBAL & WRITTEN INFORMATION AND CONFIDENTIALITY

Patient Name: _____ **DOB:** _____

Consent for the Release of Healthcare Information

I give my permission for the following individuals (include family members and friends) to receive personal health information about me. This permission will be binding until revoked by me.

- _____ Relationship to me: _____
- _____ Relationship to me: _____
- _____ Relationship to me: _____
- _____ Relationship to me: _____

Release Requiring Specific Consent

If you DO NOT WANT any of the following records released, you need to initial and sign below per 42 CFR Part 2 and RCW 70.24.

_____ HIV/AIDS _____ Mental Health _____ Reproductive Care

_____ Sexually Transmitted Diseases _____ Alcohol/Substance Use

Minors: In accordance with Washington State law, a minor patient's signature is required, NOT the parent/guardian signature regarding specific consents described above. □ *Check if patient is a minor.*

**Restrictions – Only clinical records originated through this healthcare facility will be provided unless otherwise specifically requested. This authorization is valid only for the release of information dated prior to and including the date on this form.*

_____	_____	_____
Date	Signature of Patient (minors 13-17) or Representative	Relationship if not Patient

_____

Patient/Parent/Guardian Signature Print Name Date

*I release the providers and staff from all legal responsibility and liability that may arise from the release of this information. I may revoke this consent at any time except when action has been taken. I understand I do not have to sign this authorization in order to get healthcare benefits, which include treatment, payment, or enrollment. However, I do have to sign an authorization form to take part in research studies or to receive health care when the purpose is to create healthcare information for a third party. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. Once PCHS has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

***Statement of Confidentiality:** This information has been disclosed to you from records whose confidentiality is protected by Washington State law. State law prohibits you from making any further disclosure of it without the specific written consent of the person whom it pertains or as otherwise permitted by State law. A general (blanket) authorization for the release of clinical records or other information is not sufficient for this purpose. (rv.07_2018)

Expires one year from date authorization is signed, unless specified otherwise: _____

Peninsula Community Health Services

PERMISSION TO RELEASE HEALTH CARE INFORMATION – INCOMING RECORDS

Patient's Full Name:					
Date of Birth: / /		Previous Name (if applicable):			
I HEREBY REQUEST AND GIVE MY PERMISSION TO RELEASE THE FOLLOWING INFORMATION					
INFORMATION TO BE RELEASED TO Peninsula Community Health Services					
PO BOX 960	Bremerton	WA	98337	Phone: 360-377-3776	Fax: 360-874-5595
Reason for Request: ☐Legal ☐Insurance ☐Personal Use ☐Continuing Care ☐Other: _____					
INFORMATION TO BE RELEASE FROM (must provide contact information)					
Name:			Organization:		
Address:					
City:			State:	Zip:	
Phone:			Fax:		
INFORMATION TO BE RELEASED					
☐Information from the past 2 years of care ☐Health information from _____ to _____ ☐Specific health information about _____ ☐Pap ☐Colon/FOBT ☐DEXA ☐Mammogram					
*Restrictions: Only records originating from this healthcare system will be provided unless otherwise specifically requested. This authorization is valid only for the release of information dated prior to and including the date on this form.					
Date:		Signature of patient or representative:			
Relationship if not the patient:					
RELEASE REQUIRING SPECIFIC CONSENT					
My signature above gives you permission to release **ANY and ALL** confidential information relating to testing, diagnosis, or treatment. Per 42 CFR part 2 (See * Statement Below) I understand if I initial any of the following categories of confidential information, it **WILL NOT** be released.					
_____ HIV/AIDS		_____MENTAL HEALTH		_____ SUBSTANCE USE	
_____ SEXUALLY TRANSMITTED DISEASES			_____ REPRODUCTIVE HEALTH		
Minors: In accordance with Washington State law, a minor patient's signature is required, NOT the parent/guardian signature regarding specific consents described above.					
Date:		Signature of patient (minors 13-17) or representative:			
Relationship if not the patient:					

**Records concerning substance use treatment and/or sexually transmitted diseases may NOT be disclosed by you unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by regulation (42 CFR Part 2 and RCW 70.24). An authorization for the release of medical or mental health information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute a substance use patient. Unless otherwise indicated, this release specifically allows the disclosure of mental health/psychological treatment (45 CFR Parts 160 and 164); substance use treatment (42 CFR Part 2); and the Health Insurance Portability Accountability Act of 1996 ("HIPAA") and cannot be disclosed without your written consent unless otherwise provided for in the regulations.*

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party. I understand that: a) I must revoke my permission in writing and may do so by completing and signing the Revocation of Authorization form, available at the medical office; b) if I revoke my permission, it will not affect any actions already taken by PCHS based on this permission; and c) I may not be able to revoke this permission if the purpose of it was to obtain insurance.

Once PCHS has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

Expires one year from date authorization is signed, unless specified otherwise: _____