MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS
PATIENT REGISTRATION

Date completed:_____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birth Date: _____ Birth Gender: ☐ Male ☐ Female ☐ Other: _____

School:_____ Grade: _____ Student ID#:_____

Primary language spoken at home: _____

Race (select all that apply)	Ethnicity (select only one)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Prefer not to answer	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Does your child qualify for free or reduced lunch at school? ☐ YES ☐ NO

PERSON RESPONSIBLE FOR THE PATIENT

Relationship: _____ E-mail: _____

Name: (Last) _____ (First) _____ (Middle) _____

☐ Same as Above

Address: _____ City: _____ State: _____ Zip Code: _____

Day Phone #: _____ Alternate Day Phone #:_____

EMERGENCY CONTACT INFORMATION (To be contacted if parent/guardian cannot be reached)

Relationship: _____

Name: (Last) _____ (First) _____

Day Phone #: _____ Alternate Day Phone #:_____

Parent / Guardian Signature	Print Name	Relationship to patient	Date	Time ☐ AM ☐ PM

MEMORIAL HERMANN

Health Centers for Schools Patient Registration Form

17082 (2/22)

MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS BURBANK CLINIC, HOUSTON, TEXAS

INFORMED CONSENT FOR TREATMENT AND OTHER PREVENTIVE HEALTH CARE SERVICES

PLEASE READ CAREFULLY AND FILL OUT THE CONSENT FORM BELOW FOR YOUR STUDENT TO BE TREATED AT THE HEALTH CENTER

Memorial Hermann Health Centers for Schools (MHHCS) or "Health Center" is concerned with the health of students at contracted schools. We provide a number of health care services, subject to the limitations of the facility.

THE FOLLOWING HEALTH CARE SERVICES ARE AVAILABLE AT THE BURBANK SCHOOL-BASED HEALTH CENTER.

1. Immunizations
2. Well Exams / Check-ups
3. Athletic and Camp Physicals
4. Health Education
5. Nutrition Education
6. Family Planning Services
7. Social Service Assistance
8. Treatment of minor illness and injury
9. Mental Health counseling
10. Exercise education and counseling
11. Detection and treatment of sexually transmitted diseases (STD)

Please indicate which of the following apply to the student:

☐ Medicaid # _____ Medicaid Plan _____ ☐ Harris Health/Gold Card

☐ CHIP ☐ Private Health Insurance ☐ No Insurance

IMPORTANT – PLEASE NOTE: The Health Center is a Medicaid Provider and will bill Medicaid for services to those students who have Medicaid coverage. **Non covered services will NOT be billed to the student or family.**

I authorize MHHCS to bill Medicaid or my Medicaid plan and receive payment directly from them for services rendered. I also authorize MHHCS to release information as required to Medicaid or my Medicaid plan, for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. A photocopy or a telefaxed copy of this authorization shall be deemed as valid as the original.

I authorize the Health Center staff to disclose to the school nurse, medical or athletic team appropriate health information about my child as deemed necessary, solely for treatment purposes, and for the continuity of my child's care. I further authorize school personnel to disclose grades, absenteeism, and disciplinary data for my child, if seen by the Licensed Clinical Social Worker or Licensed Professional Counselor.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

PLEASE NOTE:

Primary health care services are provided to students by a full time Advanced Practice Provider. In addition, counseling services are provided by a Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC). Services provided at the Health Center are optional and at no cost to the student or family.

I authorize a designated MHHCS professional healthcare provider to provide necessary and/or advisable treatment for the student.

_____ _____

Student Name Date of Birth

I give my permission for MHHCS to provide all services indicated above within the capabilities of the facility and its personnel except for

item(s) _____.

I authorize the above named facility to provide transportation and/or accompany my child from the contracted schools to the Health Center for services after receiving permission from the school nurse.

I have read and completed this consent form. I understand that school personnel may see this informed consent. I understand that any questions I may have concerning the Health Center will be answered by calling (713) 742-8151.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

Phone number where parent/guardian can be reached during school hours:

Name:_____ Phone Number:_____ Best time to call:_____

Email:_____

Second Parent/Guardian
Signature (optional):: _____ Phone Number:_____ Best time to call:_____

MEMORIAL HERMANN

Informed Consent

16264 (2/22)

Memorial Hermann Health System
Acknowledgment of Receipt of Joint Notice of Privacy
Health Centers for Schools

This Joint Notice of Privacy Practice applies to the privacy practices of the Affiliated Entities and the Entities participating in the Organized Health Care Arrangement. These Entities include: Memorial Hermann Hospital System, Memorial Hermann Affiliated Services, Memorial Hermann Physicians of Texas, MHMG, MHMD, MHMI, Memorial Hermann Ventures, Inc., Memorial Hermann Health Network Providers, Inc., Memorial Hermann Health System, Memorial Hermann Foundation, Memorial Hermann Professional Insurance Co. Ltd., Physicians and Allied Professionals with privileges to practice at a Memorial Hermann Healthcare Facility.

This form is used to document (a) an individual's acknowledgement of receipt of our Joint Notice of Privacy Practices or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

I (parent/guardian) acknowledge that I have received a Joint Notice of Privacy Practices from Memorial Hermann Health System.

I (parent/guardian) understand that the student's health information will be used and disclosed according to Memorial Hermann Health System's Joint Notice of Privacy Practices.

I (parent/guardian) also understand that a written authorization from me (parent/guardian) will be requested by the clinic prior to releasing health care information for any use or disclosure not listed in the Joint Notice of Privacy Practices.

Parent / Guardian Signature	Print Name	Relationship to student	Date	Time ☐ AM ☐ PM

Student Name (print)	School

STAFF USE ONLY – DO NOT WRITE BELOW THIS LINE

Good Faith Effort to Obtain Acknowledgement of Receipt of Joint Notice or Privacy Practices:

Describe your good faith effort to obtain the parent/guardian signature on this form:

_____

_____

_____

Describe the reason why the individual would not/could not sign this form:

_____

_____

_____

Staff Signature	Print Name	Date	Time ☐ AM ☐ PM

MEMORIAL HERMANN

Acknowledgment of Receipt of Joint Notice of Privacy