Enrollment Form – School Based Health Clinic

☐ Stanton ISD ☐ Glasscock County ☐ Grady ☐ Greenwood

Grade/Campus ______________________________________

Student/Patient Information

Name: (First)______________________(Last)_________________________(Middle Initial)____DOB_______

☐ Male ☐ Female Allergies ____

Primary Care Provider/Pediatrician____

Health Concerns? ____

Parent/Guardian/Responsible Party

1. Name: (First)____________________ (Last)___________________________________DOB________

   Mailing Address: _________________________________City/State__________________Zip_________

   Telephone Number: Home _________________________________Cell_________________________

2. Name: (First)____________________ (Last)___________________________________DOB________

   Mailing Address:_________________________________City/State____________________Zip________

   Telephone Number: Home _________________________________Cell_________________________

   Email ____

Insurance Carrier: ____________________________________Group Number___________________________
Subscriber Name: __________________________________Subscriber Date of birth _____________
Member #/ID ______________________________

Acknowledgements:

____ I have been informed of the HIPAA and Privacy Practices and Patient Rights and Responsibilities

____ I agree to notify Martin County Family Clinic if my insurance provider changes during the Enrollment period of the school year.

____ I acknowledge that my child may see a provider other than their primary care provider

Return Registration form along with photocopy of Insurance Card and Photo ID to:

Martin County Family Clinic – **Attention Registration**
PO Box 640
Stanton, Texas 79782

Fax - 432-607-3298 Or **Email** – registration@martinch.org

MARTIN COUNTY FAMILY CLINIC – SCHOOL BASED CLINIC
600 East I-20 ● P.O. Box 640
Stanton, TX 79782
(432) 607-3243 ● (432) 607-3298 fax
A Service of Martin County Hospital District

Consent for Treatment

I understand that if medical treatment is necessary, a physician, nurse practitioner, physician assistant, or other appropriate healthcare provider of the Martin County Family Clinic will perform such medical treatment and procedures via a telehealth visit while the patient (student) is on the school campus.

I understand that Nurse Practitioners (NP) and Physician Assistants (PA) are not physicians, but do function under the supervision of a physician, either directly or via protocols established by a physician and that NP's and PA's are formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. I also understand that ~~as~~ working as members of the health care team, NP's and PA's take medical histories, examine patients, order and interpret laboratory tests and x-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting.

Providers record progress notes, instruct and counsel patients, order or carry out therapy, or perform minor invasive procedures.

Medicare/Medicaid Patient's Certification: Authorization to release information and payment request. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits: I hereby authorize payment directly to martin county Family Clinic of healthcare benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to Martin County Family clinic and provider for charges not covered by this assignment.

Authorization for Release of Medical Information: the clinic and providers are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency, which may be assisting in payment for my care.

Refund of Insurance Benefits: I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverage's are subject to a coordination of benefits clause.

I have read and fully understand the above Acknowledgement for Treatment and hereby grant my authorization and consent for such treatment and procedures while enrolled in the school based health program with Martin County Family Clinic.

Patient/Student Name: ____

Parent/Legal Guardian Signature ____

(Guardian signature required if patient is younger than 18 or legal guardianship has been ordered)

Date: __________________________ Time: __________________________

Witness Signature: __________________________________