Kids First Health Care

Patient/Student Enrollment and Consent Form

Grade: _____ ☐ N/A **Today's Date:** _____

School Attending: ☐ N/A ☐ ACHS ☐ LAHS ☐ ACMS ☐ KMS ☐ THS ☐ BTEC ☐ BHS ☐ Other: _____

Student/Patient Information

Patient Name (First, Middle Initial, Last):	Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other _____

Address:	City:	State:	Zip Code:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/ Latino	Race: ☐ Native American ☐ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

Name of Patient's Primary Care Clinic:	Where is the clinic located?
Name of your Preferred Pharmacy:	Where is the pharmacy located?

Parent/Guardian Information

Kids First Health Care uses the following PRIVATE information for funding purposes only.

Number of immediate family members in your home: ____	Family estimated gross income: $ _____ ☐ Weekly ☐ Monthly ☐ Yearly		
Mother/Guardian Name:	Language:	Cell Number:	Email:
Father/Guardian Name:	Language:	Cell Number:	Email:

Patient Health Insurance Information

Kids First Health Care uses the following health insurance information for billing purposes when possible.

☐ Medicaid: Number _____ ☐ CHP+: Number _____

☐ Commercial/Private Insurance: *(Please submit a copy of the patient's health insurance card.)*

Insurance Name:	Member ID:	Group #:	Subscribers Name:	Subscribers Birthdate:

☐ Uninsured: *May we contact you with information regarding eligibility for Medicaid or CHP+?* ☐ *Yes* ☐ *No*

Consent and Release of Information

I have read, understand, and consent to the services offered by **Kids First Health Care (KFHC)** and am requesting said services be provided to my child. I give permission to bill my health insurance carrier for services received. I agree to notify KFHC of changes in the insurance status of my child. I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I have received a copy of the KFHC Notice of Privacy Practices. I authorize KFHC to disclose all or any portion of my child's medical record to any entity pertinent to his/her health care, including but not limited to; the contracted mental health partner that operates under the scope of the KFHC medical practice, the school administration, school health clerk/aid, school nurse, KFHC staff, and (if at an SBHC site) the patient's regular medical provider and as otherwise permitted by law. I further authorize the school district to disclose to KFHC staff and any KFHC contracted mental health partner my child's school attendance, immunization, health/disability, and other pertinent school records that may assist the KFHC staff or its subcontractor's staff in helping my child. I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services received at the school-based health centers and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and this data does not specifically identify any individual patient. I understand that KFHC maintains electronic medical records. I understand KFHC is a Colorado Immunization Information System (CIIS) authorized provider. I authorize electronic download of eligibility and medication history information. In partnership with KFHC, the contracted mental health partner provides behavioral health consultation, therapy, and counseling to children and their families to support social-emotional well-being, hope, and recovery. The Behavioral Health Professional (BHP) can also help facilitate referrals to other community providers, including access to ongoing mental health therapy, if needed. All information shared with the BHP is kept confidential unless there is a concern about safety, abuse or neglect of my child. If this child has Medicaid coverage, information regarding visits with the BHP will be shared/billed to Medicaid. I authorize electronic download of eligibility and medication history information. I understand the information on this form and agree to participate in consultation services if needed with the BHP. In partnership with KFHC, the contracted dental partners provide certain Dental services in the SBHC's at ACHS, BHS and THS. I understand that an additional Dental consent form will be required for students attending ACHS, THS and BHS. I understand that the KFHC staff or clinic partners can communicate with me via my telephone number, by call or text, and/or by email. I further acknowledge that tele-health is a service provided.

Patients under age 18 must have a signed parent/guardian consent form on file to receive most Kids First Health Care services. According to Colorado state laws, parental consent is not required for mental health, drugs and alcohol counseling for youth 12 years and older and for sexual health services for youth of any age.

(This form is valid for one year from date of signature and can be revoked at any time by summiting a written request to KFHC Administrative offices, 303-289-1086)

☐ I consent for my child/adolescent to receive health care services at the Kids First Health Care clinics/School Based-Health Centers and agree to all of the above.

☐ I do NOT consent for my child/adolescent to receive health care services for my child/adolescent at the Kids First Health Care clinics/School Based-Health Centers.

Parent/Legal Guardian Signature *(Patient only if older than age 18)*:	Date Signed:

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For Staff Use Only: **Enrollment Code:** _____ **Less than 200% of FPL:** ❑Yes ❑No **Information in IC by (initials):** _____ **Information in EMR by (initials):** _____