# Tri-Lakes Community Health Center: Child Information and Consent Form

Name _____ Soc Sec# ___-___-____ Date of Birth ___/___/

Address _____ City _____State _____ Zip_____

County _____ Age __ Sex M / F Phone #_____

Guardian Phone #_____ Cell #_____ E-Mail _____

I **do not** want to be contacted by email for: ☐ General health information including the quarterly newsletter
☐ Specific medical info about my health condition(s) ☐ Direct contact with my provider ☐ Fundraising

Please indicate if child is: ☐ Homeless Is child disabled? ☐ Yes ☐ No

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unknown

Are you of Hispanic/Latino origin? ☐ Yes ☐ No Current Student? ☐Yes ☐No

I prefer to receive information in a language other than English ☐ Language_____

How did you hear about our clinic?

☐ friend/family ☐ newspaper (please list)_____ ☐ website
☐ yellow pages ☐ sign in front of clinic ☐ billboard (Branson West) ☐ billboard (Reeds Spring)
☐ other _____ ☐ billboard (south of Kimberling City) ☐ school

**Father's Name** _____Date of Birth _____ SSN _____.

Employer _____ City _____State___ Phone _____.

Name of Insurance _____ Policy# _____
Group # _____

**Mother's Name** _____Date of Birth _____ SSN _____.

Employer _____ City _____State___ Phone _____.

Name of Insurance _____ Policy# _____
Group # _____

Do both parents live with the patient? _____ If not, who has legal custody? _____

Please describe custody agreement:_____

Family Size _____ Annual Family Income (please circle) Less than
- $10,000
- $10,001 to $25,000
- $25,001 to $40,000
- $40,001 to $55,000
- $55,001 to $70,000

Greater than $70,000

*Why are we asking for so much information? Fordland Clinic is a not-for-profit community health center, and as a non-profit, we can apply for grants to expand services. Many grant organizations request we provide demographic information about the patients we serve. Your privacy is important to us, we do not share your personal information or identity with third parties or advertising agents.*

## RESPONSIBLE PARTY/EMPLOYER INFORMATION/INSURANCE CARRIER
**(Please give all insurance cards to the receptionist)**

Person responsible for bill: _____ Date of birth: _____/___/_____

Address (if different): _____ Phone: _____

Employer: _____ Employer Phone: _____

Method of Payment: Insurance_____ Cash_____ Credit Card _____

**Primary Medical Insurance:**
☐ Medicaid ☐BCBS ☐UHC ☐Mercy ☐Cox ☐ Other:_____

**Secondary Medical Insurance**:
☐ Medicare ☐ Medicaid ☐BCBS ☐UHC ☐Mercy ☐Cox ☐ Other:_____

**Dental Insurance Company:** _____Policy#_____Group#_____

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child ☐Step Child ☐Other:_____

**Consent for Treatment:** This is to certify that I, the undersigned, consent to the administration of whatever anesthetics and the performance of whatever medical and/or dental procedures that may be decided on by myself and the attending medical/dental provider to be necessary or advisable, rendered via face-to-face interaction or telemedicine. I, hereby voluntarily request, consent to, and authorize Fordland Clinic dentists, hygienists, physicians, Nurse Practitioners, behavioral health clinicians or other practitioners to provide medical and surgical treatment, including but not limited to, diagnostic procedures, lab testing, and administration of medications, as is deemed necessary and advisable. I further understand and acknowledge that HIV and Hepatitis testing may be performed upon my child, or me without written consent, under the circumstances that a Fordland Clinic employee sustains a percutaneous mucous membrane or other exposure to my blood or other bodily fluids.

**Information:** I certify the information that I have given in this form is correct. Should there be any changes, I will notify the dentist prior to treatment.

**Assignment of Insurance benefits:** I request payment of authorized Medicaid &/or other Insurance benefits on my behalf for any services furnished to me by Fordland Clinic, Inc. I agree to pay any collection fees in the event that my account is turned over to a collection agency for failure to pay outstanding charges for more than 3 months. I understand that I may be responsible for additional charges generated from abnormal lab or pathology results.

**Release of Information:** I also authorize Fordland Clinic, Inc. to release the minimum necessary medical and/or billing information concerning my care, including copies of my medical records, electronically or on paper, for the purpose of ongoing medical treatment and billing for services provided. I acknowledge that this authorization is valid for one year, or until all accounts are settled. *While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.*

**Photo Release:** I give Fordland Clinic (FC) the right to use my name, photograph, image or voice in all forms for promotion of FC or media coverage of FC and its events with no monetary compensation to myself.

**HIPPA:** I acknowledge that I have been notified of FC's HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices. I have been given a chance to review them and offered a copy. I also acknowledge that if I wish to have a copy, in the future, it is available to me. I understand that general e-mail is not a secure method of communication, and if I send e-mail to a provider or request a provider respond to me by e-mail I acknowledge that I am aware that this is not secure, and is not compliant with HIPA rules & regulations.

_____ _____

Patient/Parent/Guardian Signature Date Witness Date

Name of family health care provider: _____
Name of family dental care provider: _____