Brewer School-Based Health Center
Enrollment Form

Please complete and sign this form if you would like to give permission for your child to use the Brewer School-Based Health Center (SBHC).

I give permission for my child, _____, to use the School-Based Health Center for the duration of my child's enrollment at the Brewer Schools which will include medical, dental, or mental health counseling services.

Please check the services that you would like your child to be able to receive, if needed, during the school year: ☐ Medical Only ☐ Medical with Mental Health Counseling

Name of Student: _____ **Date of Birth:** _____
Gender: ☐ Male ☐ Female **Grade:** _____ **Student SSN#:** ___ ___ ___-___ ___-___ ___ ___ ___
Race: ☐ Caucasian ☐ Native American ☐ Asian American ☐ Hispanic ☐ African American ☐ Other

Parent/Guardian Information
Parent/Guardian's Name: _____ Cell Phone: _____
Home Phone: _____ Work/Daytime Phone: _____ ☐ Okay to call work
Home Address: _____

Parent/Guardian's Name: _____ Cell Phone: _____
Home Phone: _____ Work/Daytime Phone: _____ ☐ Okay to call work
Home Address: _____

Is there a court order affecting your child in regard to custody, residence, or visitation rights? _____

Insurance Information
Health Insurance Name: _____ **Policy #:** _____
Policy Holder Name: _____ **Group #:** _____
☐ Please check here if you do not have health insurance (Affordable Care Program Available)

Primary Health Care Provider (PCP)'s Name: _____
PCP Phone #: _____ **Date of last well child exam:** _____
☐ Do not have a PCP ☐ I would like the health center to become the PCP

Please indicate below which billing/payment option you choose for services:
____ Please bill my health insurance for medical services.
(Parent/Guardian will be billed for any deductible or remaining balance after insurance).
____ My child has MaineCare (Medicaid). Please bill MaineCare for medical services.
____ My child is not covered by health insurance (Affordable Care Program Available).
*** Please notify us of any changes to your insurance to ensure billing to correct insurance.*

[Turn Page Over]

Name of Student: _____ Date of Birth: _____

- I understand that I may withdraw this consent at any time by signing the "Withdrawal of Parent Consent" form.
- I understand that all parent consent forms remain part of the permanent medical record. The consent is valid for the duration of the student's eligibility at the SBHC. If a subsequent consent form is submitted, it supersedes all prior consent.
- I understand that my signature also gives permission for the School-Based Health Center staff to access my child's school health record, share health information with my child's doctor or dentist and share information with the school nurse and school social worker/guidance counselors when it is deemed appropriate for treatment purposes.
- I understand that the health center provides services that complement (but do not replace) those provided by my child's primary health care provider (PCP). If my child needs a service that the health center is unable to provide, I understand that the health center staff will refer to my child's primary health care provider (PCP) for that service.
- I understand that when I enroll my child, children in the 6th through 12th grades will be scheduled for an annual appointment with the clinic to administer a health questionnaire that is used state-wide. My insurance may be charged for this visit, but I will not be responsible for any out of pocket expense.
- If my child does not have a PCP, I understand that the health center will become PCP if I so request.
- Medical records will be kept in a confidential manner; however, I acknowledge that the School-Based Health Center may release information regarding treatment to third party payers, such as MaineCare, Anthem or other health insurance companies, for the purpose of billing and for any reason in accordance with acceptable medical practice and pursuant to law.
- I understand that under Maine State Law, my child may consent for certain health care services without parental permission and unless failure to notify parent or guardian would seriously jeopardize the health of the minor, the practitioner will honor the confidentiality of the student.
- In case of accident or serious illness, I request the school clinic to contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements are deemed necessary.

For your convenience, a copy of our Notice of Privacy Practices is available on our website PCHC.com. Please call 207-992-9200 ext. 297 if you would like to request a paper copy.

☐ I have been offered a copy of Penobscot Community Health Care's Notice of Privacy Practices.

_____ _____

Signature of parent/guardian or student (age 18 and older) Date

PLEASE RETURN FORM TO BREWER SCHOOL-BASED HEALTH CENTER

CONFIDENTIAL