Hawse Health

E. A. HAWSE HEALTH CENTER
SCHOOL BASED HEALTH REGISTRATION FORM

Child Name: _____ Date of Birth:_____

Parent
Signature:_____

Phone Number: _____

- ☐ **YES!** I give consent for my child to participate in services offered at the School Based Wellness Center. I understand billable visits will only be provided with permission prior to the time of services. **My child is a Hawse Health Center patient.** They are seen at Grove Street, Potomac Valley Family Medicine, Hardy County Medical, Baker, Wardensville Medical, Romney Medical, or Mathias. I do not need to complete the attached paperwork.

- ☐ **YES!** I give consent for my child to participate in services offered at the School Based Wellness Center. I understand billable visits will only be provided with permission prior to the time of services. **My child IS NOT a current Hawse Health Center patient.** I have completed the attached forms necessary so my child can be seen.

- ☐ **No!** I do not give consent for my child to participate in services offered at the School Based Wellness Center.

Hawse Health

(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801
HAWSEHEALTH.COM

Acknowledgments

I acknowledge that I have received and understand E. A. Hawse Health Center's *Payment and Scheduling Policies*. I further understand that E. A. Hawse Health Center may update these policies any time and that I may receive an updated copy by submitting a request in writing.

I acknowledge that I have received and understand E. A. Hawse Health Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that E. A. Hawse Health Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of E. A. Hawse Health Center's *Notice of Privacy Practices* by submitting a request in writing.

I give permission for E. A. Hawse Health Center to release information to the following:

NAME	RELATIONSHIP	PHONE NUMBER

If your child needs to be seen at school or at one of our offices, please list anyone who has permission to bring your child for medical, dental, or behavioral health treatment:

NAME	RELATIONSHIP	PHONE NUMBER

Do you consent to receive medical text messages for appointment reminders, appointment confirmations, and other important communications? ☐Yes ☐No

May we leave medical information such as test results on your answering machine? ☐Yes ☐No

Printed Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

If completed by patient's personal representative, please print and sign below.

Printed Patient Personal Representative Name _____ Relationship to Patient _____

Patient Personal Representative Signature _____ Date _____

☐ Please keep this signature on file should I have to pay for services using my credit card

For E. A. Hawse Health Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative. E. A. Hawse Health Center made a good faith effort to obtain patient's written acknowledgment of the Payment and Scheduling Policies and Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign ☐ Other
☐ Patient or patient's personal representative unable to sign

Printed Employee Name/Signature _____ Date _____

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Accessible Affordable Quality Care Since 1981

E. A. HAWSE HEALTH CENTER
SCHOOL BASED HEALTH REGISTRATION FORM

- ☐ **YES**! I give consent for my child to participate in services offered at the School Based Wellness Center. I understand billable visits will only be provided with permission prior to the time of services.
- ☐ **No**! I do not give consent for my child to participate in services offered at the School Based Wellness Center.

School:	**Grade:**	**Teacher:**

PATIENT INFORMATION

Student's last name: First: Middle:	Birth Date:	Sex: Male☐ Female☐	Social Security No:

Street address:	P.O. Box:	City:	State:	Zip Code:

Parent/Guardian Name:	Best daytime phone number: Home phone number: Cell phone number:	Parent Date of Birth Parent Social Security #

Street address:	P.O. Box:	City:	State:	Zip Code:

Race: White☐ Black☐ American Indian or Alaskan Native☐ Asian or Pacific Islander☐ Other☐ _____
Ethnic Origin: Caucasian or White☐ Hispanic or Latino☐ Hispanic Latino/Black☐ Not of Hispanic or Latino☐ Declined☐ Unknown☐
Language: English☐ Spanish☐ Other☐ _____
Sexual Orientation: Straight☐ Lesbian or gay☐ Other: _____
Gender Identity: Male☐ Female☐ Transgendered Male/Female☐ Transgendered Female/Male☐ Declined☐ Other _____

Does your child have any medical problems? If yes, please explain: _____

Is your child allergic to medications: ☐ Yes ☐ No If yes, please list: _____

Is your child taking any medications on a regular basis? ☐ Yes ☐ No If yes, please list the medications and dose: _____

_____

Have there been any major changes in your child's health since the last school year? (For example, a newly diagnosed illness, a surgery, a hospital stay, etc.) _____

_____

Who is your child's doctor? _____ **Pharmacy of choice** _____

IF WE ARE UNABLE TO CONTACT YOU, WHO SHOULD WE CALL?

Name: _____ Phone# _____ Relationship to child _____

Name: _____ Phone# _____ Relationship to child _____

Patient ☐will enroll in Sliding Fee Program. **OR** Patient ☐will not enroll in Sliding Fee Program and has declined coverage.

INSURANCE INFORMATION

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD WITH THIS FORM

Is this patient covered by insurance? ☐Yes ☐No	Name of Primary Insurance:

Subscriber's Name:	Subscribers Social Security #:	Birth Date:	Group No:	ID No:	Co-Payment: $

Subscribers Address:	Home phone:

Occupation:	Employer:	Employer Address:	Employer Phone No:

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

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

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

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to E. A. Hawse Health Center. I understand that I am financially responsible for any unpaid balance. I also authorize E. A. Hawse Health Center to release any information required to process my insurance claim. I authorize E. A. Hawse Health Center's medical, dental, and behavioral health staff to consult together and to perform needed treatments and/or diagnostic tests for necessary care including medical, dental, or behavioral health services.

_____ _____
Patient/Guardian Signature *Date*
Email Address: _____

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E. A. Hawse Health Center
School Based Health Centers
Moorefield, East Hardy, Petersburg, Romney, and Capon Bridge sites

Frequently Asked Questions

What Services are offered at the center? The School Based Health Center's are staffed by Certified Physician Assistants or Certified Nurse Practitioners and experienced medical assistants. These providers can perform urgent visits such as acute illnesses and injuries. Well visits such as physicals, immunizations, and sports physicals are also available. The management of chronic conditions such as Asthma and Diabetes are also within the scope of practice of our providers. The school based health centers can give complimentary over-the counter medications for minor ailments such as headache, upset stomach, etc. If the provider evaluates your child it will be considered a patient visit that will be billed to your child's insurance.

What is the difference between the school nurse and school based health center? The School Based Health Center staff is employed by E. A. Hawse Health Center. The school nurse is employed by the school district. The School Based Health Center requires a consent form to diagnose, treat and administer medications. You, as the parent or guardian, are responsible for the cost. The School Based Health Center is an extension/satellite of E. A. Hawse Health Center.

My child already has a regular doctor, why should I sign the consent form? We certainly are not meant to take the place of your family physician. However, in case your child becomes sick or injured while at school the health center staff can provides an immediate alternative. This option may allow you to remain at work rather than come to the school to pick up your child.

How do I get my child an appointment at school? For your child to be seen by our provider we must receive permission by phone or in writing from the parent or guardian. After your child is evaluated, the provider will contact you by phone to discuss the visit.

Will I get a bill if my child comes to your office? You are only billed for a visit if permission has been received or a visit has been requested. You will not be billed for basic items such as your child getting their temperature taken, over the counter medication we administer, blood pressure checks, etc. The only time you will be charged for a visit is when you have granted permission for our provider to treat or evaluate your child. In the case of emergencies, our providers will evaluate your child without delay to ensure the child's well being.

How am I billed for the visit? Our home office located in Baker, WV will bill your child's insurance based on the information that we have on file. The insurance information is requested on the enclosed form. A copy of the insurance card is requested. Should the insurance information change during the course of the school year, please be sure to provide a copy of the new insurance card. If you do not have insurance coverage for your child you will receive a bill for the visit through the US Mail.

Who will my child see? Jessica Riggleman, FNP-C is the provider that will evaluate your child at the Moorefield schools, Elizabeth Hott, FNP-C is the provider that will evaluate your child at East Hardy schools, Loren Cunningham, PA-C is the provider at the Petersburg schools and Kelli Eglinger, PA-C is the provider at the Hampshire County Schools.

How can I contact the School Based Wellness Center?
Moorefield Elementary School 304-530-6356
Moorefield Intermediate School 304-530-5010 or 304-530-3450
East Hardy Early Middle School 304-897-7108
Petersburg Elementary School 304-257-1110
Petersburg High School 304-257-1444
Hampshire High School 304-822-5016
Capon Bridge Middle School 304-856-2534
Romney Middle School 304-822-5014
West Virginia School for the Deaf and Blind 304-822-4860

Hawse Health

Due to COVID-19, School Based Health Clinics are for school children only.

If your child is sick and does not go to school, please call any Hawse Health Center clinic to schedule an appointment

Baker:	304-897-5915
Mathias:	304-897-7400
Moorefield:	304-538-2331
Petersburg:	304-257-2451
Romney:	304-822-3838
Wardensville:	304-874-4012