GENERATIONS FAMILY HEALTH CENTER

Patient Information & Consent for Treatment

School:
Grade:

If you would like to enroll/re-enroll your child in this program, please answer ALL questions on this form. Thank you.

Child's Name: (first) _____ (last) _____MI _____
SS#: _____-_____-_____

Child's Home Address: (street) _____

(town) _____ (zip code) _____

Patient's Housing Status: (check one) □ Homeless Shelter □ Transitional □ Doubling Up □ Street □ Own □ Rent

Date of Birth: _____/_____/_____ ☐ Male ☐ Female Primary Language: _____

Child's Race: (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐Other: _____

Ethnicity**:** Is the child of Hispanic Origin? ☐ Yes ☐ No

Parent/Guardian Name: (first) _____ (last) _____

Relationship to Child: _____ DOB:_____ /_____ /_____

Address: (street) _____ (town) _____ (zip code) _____

Daytime Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Please complete information below on any insurance coverage you child may have at this time.

	Medical Insurance	Dental Insurance	Behavioral Health Ins.	Secondary Insurance
Plan Name:				
Policy #				
Group #				
Subscriber Name:				
DOB:				
Relationship:				

If your child has no insurance, would you like to talk with our staff about health care coverage? □ Yes □ No

PT#

Please continue to next page ➡

Name:_____ DOB:_____

School:
Grade:

INCOME DOCUMENTATION

It is the policy of Generations Family Health Center, Inc. to provide essential services regardless of the patient's ability to pay. Discounts may be offered based upon family/household size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

Family size: _____(including unborn child if pregnant)

Household gross income: $_____ per (circle one): WEEK BIWEEKLY MONTH YEAR

All of the above information is required

Families who meet certain income guidelines are eligible to apply for sliding fee scale discount. Please contact our office if you would like more information on how to apply for this discount. We reserve the right to verify eligibility for reduced charges. Pay stubs or other financial information may be required.

Effective March 1, 2017		2017 Federal Poverty Guidelines – Income Ranges						
Family Size	**<100%**	**101-125%**		**126-150%**		**151-200%**		**200%+**
		FROM	**TO**	**FROM**	**TO**	**FROM**	**TO**	**AT LEAST**
1	$ 12,060	$ 12,061	$ 15,075	$ 15,076	$ 18,090	$ 18,091	$ 24,120	$ 24,121
2	$ 16,240	$ 16,241	$ 20,300	$ 20,301	$ 24,360	$ 24,361	$ 32,480	$ 32,481
3	$ 20,160	$ 20,421	$ 25,525	$ 25,526	$ 30,630	$ 30,631	$ 40,840	$ 40,841
4	$ 24,420	$ 24,601	$ 30,750	$ 30,751	$ 36,900	$ 36,901	$ 49,200	$ 49,201
5	$ 28,780	$ 28,781	$ 37,975	$ 35,976	$ 43,170	$ 43,171	$ 57,560	$ 57,561
6	$ 32,960	$ 32,961	$ 41,200	$ 41,201	$ 49,440	$ 49,441	$ 65,920	$ 65,921
7	$ 37,140	$ 37,141	$ 46,425	$46,426	$55,710	$ 55,711	$ 74,280	$ 74,281
8	$ 41,320	$41,321	$ 51,650	$51,651	$61,980	$ 61,981	$ 82,640	$ 82,641

**The federal poverty guidelines are updated annually.*

PERMISSION TO TREAT

Please read the information below, and indicate which services you would like available to your child, and your consent for that treatment to occur. We will always have contact with you prior to your child being seen for any service, but this written permission will assist the process when your child needs care. Medical care is provided by a Nurse Practitioner (APRN), Dental care by a Hygienist (RDH), and Behavioral Health Care by a Therapist (LPC/LCSW). This permission extends throughout the 2016-2017 school year.

I give my permission to provide the following care for my child: **(*please circle each you are consenting to)***

MEDICAL CARE **DENTAL CARE** **BEHAVIORAL HEALTH CARE**

1. I understand I will be informed of all treatment received, as allowed under CT State Law.
2. I understand and allow for the following, regarding the release of information on my child's health care: I understand that you will bill my insurance. If I do not have insurance I understand that I am responsible for payment and am able to make arrangements for a payment plan. I allow the release of information as needed for billing purposes and will request that the insurance company address claims by directing payment to Generations Family Health Center, Inc. It is my right to so assign these benefits.
3. I also give permission to share health information with the school nurse and insurance companies as it relates to treatment that may be provided.
4. My signature below affirms my consent to the above Permission for Treatment and I also affirm that the information given on **all parts** of this form, including the Health History and the insurance information is accurate and complete to the best of my knowledge.

   Parent or Guardian Signature: _____ Date: _____

   Printed Name: _____ Relationship: _____

NOTE: If you are a Legal Guardian, please attach copies of the court record documenting this.