General Information

Mission: Keep children and youth healthy, in school, and ready to learn.

Vision: All students have a right to access quality integrated health care in a caring and supportive environment that optimizes education, health, and well-being.

Facts:

- Services are available to all students in Montezuma County.
- For medical health services, insurance is accepted (Medicaid, CHP+ and private insurance).
- A sliding scale applies for uninsured patients.
- For behavioral health services, uninsured and private insured patients will be placed on a sliding fee scale.
- Additional charges might apply for laboratory tests.
- Each month, a patient statement indicating full charges, discounts and balance will be mailed to the home address.
- **No one will be turned away due to inability to pay.**
- Appointments are preferred, but walk-ins are accepted (when available).

To Make Appointments:

- Southwest Open School campus: Please call 970-560-5056
- Dolores School District campus: Please call 970-560-4890

Registration forms may be dropped off at the clinics, emailed to 4CYC@everychildpediatrics.org, or faxed to 970-564-1654 (Cortez) or 970-459-3120 (Dolores).

Staff:

- Michelle Rhonehouse, FNP - Nurse Practitioner
- Patricia Nelson, LPC – Behavioral Health Provider
- Eli Cover, LPC – Behavioral Health Provider
- Julie Hite, RN – Registered Nurse
- Karen Ragland – Medical Receptionist/LPN - SWOS
- Amy Gordanier – Medical Receptionist – SWOS
- Debra Frans – Medical Receptionist – Dolores
- Sarah Jones – Program Manager

Typical Conditions Seen at the School-Based Health Center:

- Colds, flu, sore throats
- Stomach upset- nausea, vomiting, diarrhea longer than 24 hours
- Recurrent headaches
- Muscle sprains, joint pains
- Well child exams
- Skin problems and rashes
- Nutrition
- Sports physicals
- Follow up and monitoring of chronic medical conditions like diabetes and asthma in conjunction with patient's family physician
- Menstrual disorders
- Urinary tract infections
- Health questions and personal health education
- Mental health assessments and therapy
- Dental services (including education, screening, and appropriate referrals for dental care)

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Four Corners Youth Clinics

every child PEDIATRICS

Registration Form

Services include: ● Primary Care ● Physical Exams ● Immunizations ● Dental Clinics ● Behavioral Health Services

Legal Patient Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Legal Sex:** ☐ M ☐ F **Gender Identity:** _____ **Pronouns:**_____

School Attending: _____ **Grade Level:** _____ **Patient Email:**_____

Patient Cell Phone #: _____ **Permission to Call/Text:** ☐ Yes ☐ No

Race: ☐ Hispanic ☐ Asian ☐ Black or African American

☐ White ☐ Native American ☐ Hawaiian/Pacific Islander ☐ Other or Undetermined

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Address: _____ **Zip:** _____

Parent/Guardian Name: _____ **Phone #:** _____

Parent/Guardian Email: _____ **Permission to Call/Text**: ☐ Yes ☐ No

Family Information

Parent/Guardian #1 Name: _____ **DOB**:_____ **Relationship**: _____ **Phone #:**_____
(With whom the child lives)

Parent/Guardian #2 Name: _____ **DOB**:_____ **Relationship**: _____ **Phone #:**_____
(With whom the child lives)

Address: _____ **Apt #** _____ **City:** _____ **County:** _____ **Zip Code:**_____

Emergency Contact: _____ **Relationship:** _____**Phone #:** _____
(Aside from those that live with child (patient) at home)

Health Insurance: ☐ None ☐ Private ☐ Medicaid ☐ CHP+ ☐ IHS

Insurance Co. Name:_____ **ID #**:_____ **Group #:** _____

Primary Provider: _____

FOR MEDICAL SERVICES - MUST SHOW INSURANCE CARD AT TIME OF VISIT OR SIGN INCOME ATTESTATION FORM FOR SLIDING FEE SCALE.

FOR BEHAVIORAL HEALTH SERVICES – UNINSURED AND PRIVATE INSURED PATIENTS WILL BE PLACED ON A SLIDING FEE SCALE.

PRINTED name of parent/guardian:_____

SIGNATURE of parent/guardian: _____ **Date:** _____

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History Form

Legal Patient Name:_____ **Date of Birth**:_____ **Legal Gender**:_____

Current Medications: ☐ None ☐ Yes _____

Allergies (medications/food/insects): ☐ None ☐ Yes _____

Have you <u>ever</u> had or experienced *(Check all that apply)*:

☐ Arthritis	☐ Asthma	☐ Anemia	☐ Diabetes	☐ Mono
☐ Heart Problems/Murmur	☐ High Blood Pressure	☐ Kawasaki Disease	☐ Sickle Cell	☐ Seizure
☐ Skin rash or infections	☐ Stress fracture	☐ Broken bone	☐ Eye injury	☐ X-Ray
☐ Torn ligament/tendon	☐ MRI/CAT Scan	☐ Bulge or pain in groin area	☐ Surgery	
☐ Head Injury or Concussion	☐ Dislocated joint	☐ Spent night in hospital	☐ Wear glasses/contacts	

Where were you born?_____

At birth, were you born: ☐ Premature ☐ Missing any organs ☐ Heart problems/surgery as a baby

When you exercise, have you ever:

Passed out or nearly passed out? ☐ Yes ☐ No
Had any discomfort, pain, heaviness or tightness in your chest? ☐ Yes ☐ No
Cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
Felt your heart race or skip beats? ☐ Yes ☐ No
Get shorter of breath than expected? ☐ Yes ☐ No
Have any joints that become red, swollen, or painful? ☐ Yes ☐ No
Any bones, muscles, or joints that bother you? ☐ Yes ☐ No
Have you ever used an inhaler? ☐ Yes ☐ No
Had headaches? ☐ Yes ☐ No
Had numbness, tingling, or weakness in arms or legs? ☐ Yes ☐ No
Become ill when exercising in the heat? ☐ Yes ☐ No
Regularly use a brace or other device? ☐ Yes ☐ No

Do you worry about your weight? ☐ Yes ☐ No If yes, are you wanting to: ☐ Gain weight ☐ Lose weight
Any special diet or foods you avoid? _____

Girls: Have you ever had a menstrual period? ☐ Yes ☐ No If yes, how old were you when you started?_____

Family History: Does anyone in ***your family*** have: ☐ High Blood Pressure ☐ Severe allergies ☐ Asthma
☐ Sickle Cell ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Heart Problems

Additional comments:_____

_____

Parent/guardian signature: _____ Date: _____

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Consent for Treatment

Parental Consent: I understand that my child may be seen at Four Corners Youth Clinics (4CYC) only with my consent if under 18 years of age or not emancipated, or able to provide minor consent in accordance with Colorado state law, and that this consent will remain in force through the age of 21 or until I revoke said consent in writing. It is my responsibility to notify the clinic about changes in guardianship or insurance. The only exceptions to this policy are: a student may be seen one time to discuss the need for services; services will be provided in case of any emergency.

Release of Information: 4CYC is a HIPAA compliant school-based health center. Information in my child's healthcare record is confidential and will not be released to any unauthorized person or agency without written consent. In conformance with Colorado law guiding all medical facilities, my son/daughter may request that visits and health information remain confidential, under some circumstances. For me or any other party to have access to healthcare records regarding such information, my child must complete a written release.

Data Sharing Information: I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for health services I/my child receives at this school-based health center 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.

Coordination of Care/Billing: I authorize 4CYC to disclose all or any portion of my child's healthcare record to any person or entity performing record keeping or billing services for the 4CYC and any person or entities performing billing on behalf of 4CYC. I give consent to the 4CYC staff to review my child's school records, attendance, and other records that may assist 4CYC providers to help my child. I also authorize the staff of 4CYC to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including his/her primary care provider, school nurse or school health paraprofessionals, mental health providers, Every Child Pediatrics staff, the Food Service Director, the Montezuma County Public Health Department, and/or employees of the Dolores School District RE-4A/Montezuma-Cortez School District RE-1 who, as determined by 4CYC, are closely involved with monitoring my child's welfare and have a reasonable need to know such information. I understand that if my child is scheduled for an overnight school trip, basic medical information such as allergies, immunization status, past medical history, and current meds may be shared with the supervising teacher to provide for a safe and healthy environment during the trip. I also give consent to access my child's school immunization information and for it to be entered into the Colorado Immunization Information System (CIIS).

I give my consent for named patient to receive necessary and/or advisable health services from staff of 4CYC.

☐ **I acknowledge receipt of the Notice of Privacy Practices and Patient Bill of Rights and Responsibilities:**

Patient Name:_____

PRINTED name of parent/guardian:_____

SIGNATURE of parent/guardian: _____**Date:** _____

Reviewed 2/24/23

Four Corners Youth Clinics

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Income Attestation for Sliding Fee Scale

Legal Patient Name:_____ Date of Birth:_____

You **MUST** answer the questions below **IF YOUR CHILD DOES NOT HAVE HEALTH INSURANCE** or Medicaid (or if your child's insurance or Medicaid/CHP+ application is pending). If your child does have health insurance benefits that will cover the cost of his/her visit today, you do not need to answer these questions.

Behavioral health services are limited to billing Medicaid and United Health/RMHP at this time. All other rendered services for behavioral health will need to be on a sliding fee scale for uninsured patients and patients with private insurance coverage. Payment is collected at the time of the appointment.

1. How many people live in your household? (Circle one)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 or more

2. Roughly, what is your family's gross total income per year, before taxes?

$_____/Year

I certify that the above family financial information is true and accurate to the best of my knowledge. I understand that this information needs to be updated yearly, and I will be asked to sign this form at such time. You may also update this form as your income changes at any time.

Parent/Guardian Signature:_____ Date:_____

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Notice of Privacy Practices for Protected Health Information

This school-based health center is permitted by federal privacy laws to make uses and disclosures of your protected health information for the purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

TREATMENT: We will use and disclose your protected information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, if, during the course of your treatment, the physician determines he/she will need to consult with a specialist, he/she will share the information with such specialist and obtain his/her input.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. If the health insurance company requests information from us regarding your care, we will provide that information to them.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such business associates as necessary to obtain these services; or a school nurse, school health paraprofessional or daycare provider to assure children attend school in a healthy state.

We may use or disclose, as needed, your protected health information in the following situations without your authorization. These situations include: as Required by Law, Communicable Disease, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of Every Child Pediatrics. The information in it, however, belongs to you. You have the following right:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this

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Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you, by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____

Date: _____ Patient Name: _____ DOB: _____

Patient Notification of the Use of Health Information Exchange

Every Child Pediatrics endorses, supports, and participates in the electronic Health Information Exchange (HIE) as a means to improve the quality of your child's health and healthcare experience. HIE provides us with a way to securely and efficiently share your child's clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your child's healthcare providers to more effectively share information and provide your child with better care. The HIE also enables emergency medical personnel and other providers who are treating your child to have immediate access to their medical data that may be critical for their care. Making your child's health information available to their healthcare providers through the HIE can also reduce costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt out of, on behalf of your child, participation in Every Child Pediatrics HIE, or cancel an opt- out choice at any time.

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Patient Bill of Rights and Patient Responsibilities

Four Corners Youth Clinics support the rights of all patients. These rights may be exercised through the patient individually or through their surrogate decision-maker/legal representative.

You have the right to…

- Be informed of your patient rights in advance of receiving or discontinuing care.
- Have impartial access to care. No one is denied access to treatment because of disability, national origin, culture, age color, race, religion, gender identity, or sexual orientation. No one is denied treatment of an emergency medical condition because of their source of payment.
- Give informed consent for all treatment and procedures with an explanation in layman terms of:
  - **a.** Recommended treatment or procedure
  - **b.** Risks and benefits of the treatment or procedure
  - **c.** Likelihood of success, side effects and risks including death
  - **d.** Alternatives and consequences if treatment is declined
  - **e.** Explanation of the recovery period
- Participate in all areas of your care-plan, treatment, care decisions, and discharge plans.
- Have appropriate assessment and management of your plan.
- Be informed of your health status.
- Be treated with respect and dignity.
- Personal privacy, comfort and security to the extent possible during your time at the clinic.
- Be free from seclusion or restraints.
- Confidentiality of all communication and clinical records related to your care.
- Have access to telephone calls.
- Have the right to choose a visitor who maybe with you during your visit as appropriate.
- Have access to interpreter services at no cost to you.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Have access to protective services.
- Request medically appropriate and necessary care.
- Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
- Consent or refuse to participate in any study, trial, research program.
- Receive information about Advance Directives per request.
- Participate in decision-making regarding ethical issues, personal values or beliefs.
- Have access to your clinical records within a reasonable timeframe.

Patient Responsibilities:

- Ask questions and promptly voice concerns.
- Give full and accurate information as it relates to your health, including medications.
- Report changes in your condition or symptoms, including pain and request assistance of a member of the health team.
- Participate in the planning of your care, including discharge planning.
- Follow your recommended treatment plan.
- Be considerate of other patients and staff.
- Secure your valuables.
- Follow facility rules and regulations.
- Respect property that belongs to the clinic.
- Understand and honor financial obligations related to your care, including understanding your own health insurance.

Note: A copy of this document can be provided to you at the time of your appointment if requested.

Reviewed 2/24/23

Authorization for Disclosure of Protected Health Information

Four Corners Youth Clinics keeps medical records confidential. In order to provide the best health care for your child, we request your permission to release prior records to our clinic.

Patient Name:_____**DOB**:_____

Name of Person(s)/Organization for Exchange of Information From:

1. **Name**:_____**Phone**:_____

   Address:_____

2. **Name**:_____**Phone**:_____

   Address:_____

Release to:
Four Corners Youth Clinics - Cortez
P.O. Box 1701, Cortez, CO 81321
Ph: (970) 560-5056 Fax: (844) 819-9153

Information to be Released:

☐ Primary Care Record ☐ Behavioral Health Record ☐ Labs ☐ Immunization Record
☐ ER Report ☐ Reproductive Health ☐ Surgical Record ☐ Discharge Summary
☐ Consultations ☐ Entire Record ☐ Other:_____
Specific Dates:_____

Reason for Disclosure:

☐ Physician Change ☐ Insurance ☐ Other:_____

I certify that this request has been made voluntarily and that the information above is accurate. Disclosure of information between entities will follow minimum guidelines necessary. I understand that this consent may be revoked at any time, in writing, with the exception that disclosure of information has already occurred prior to the receipt of the revocation by the above-named provider. This authorization will be considered valid for one (1) year not to exceed 365 days from the date of signing.

Individual Patient's signature: I have read and agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organization named in this form.

Parent/Guardian Signature:_____**Date**:_____

Parent/Guardian:_____**Date**:_____

Relationship to Patient:_____

Student Signature:_____**Date**:_____