A Plus KidCare
Registration Form
2024-2025 School Year

School: _____
Grade: _____
Teacher: _____

CHILD'S INFORMATION
Please complete the following information about your child:

Last Name: First: Middle:

Street Address: PO Box: City: State: Zip:

Home Phone: Cell Phone: Email Address:

Date of Birth: Social Security #: Birth Sex: ☐ Male ☐ Female

Language: ☐ English ☐ Spanish ☐ Other: Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

Check all that apply ☐ Veteran ☐ Seasonal Worker ☐ Migrant Worker ☐ Homeless ☐ Limited English Proficiency ☐ Public Housing

RESPONSIBLE PARTY INFORMATION
Please complete the following information for the child's responsible party:

Parent/Guardian ρ Name:	Parent/Guardian 2 Name:
Date of Birth: Sex: ☐ Male ☐ Female	Date of Birth: Sex: ☐ Male ☐ Female
Address:	Address:
City: State: Zip:	City: State: Zip:
Cell Phone: Email Address:	Cell Phone: Email Address:
☐ Check this box if this person is financially responsible for patient	☐ Check this box if this person is financially responsible for patient

EMERGENCY CONTACT INFORMATION
Please list someone other than the child's legal guardian's

Name: Relationship: Cell Phone:

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name:	**Secondary** Insurance Company Name:
ID Number: Group Number:	ID Number: Group Number:
Name of Policy Holder:	Name of Policy Holder:
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:

☐ Check this box if you do not have medical insurance. You may be contacted by our Community Health Worker.

DISCOUNT ELIGIBILITY PROGRAM

As a Federally Qualified Health Center, A Plus KidCare is required to collect the following information to ensure we are providing the appropriate medical care and financial assistance, as needed.

A PLUS KIDCARE offers a Discount Eligibility Program to patients who are un-insured and under-insured. If you qualify, our Community Health Worker will contact you to finish the application process.

Household is anyone who lives in your home.

Household income is the sum of money earned by anyone in the household over the age of 18.

How many people live in your household? _____

What is your annual household income? _____

☐ I am interested in the Discount Eligibility Program.

☐ I am not interested in the Discount Eligibility Program.

_____ _____

Patient/Guardian Signature **Today's Date**

CHILD'S MEDICAL HISTORY

Past Medical History

- ☐ No Past Medical History
- ☐ Asthma
- ☐ Anemia
- ☐ Anxiety
- ☐ Congenital Heart Defect
- ☐ Concussion or Head Trauma
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Hernia
- ☐ Sickle Cell Anemia
- ☐ RSV
- ☐ MRSA Skin Infection
- ☐ Cardiomyopathy
- ☐ Cerebral Palsy
- ☐ Measles
- ☐ Mumps
- ☐ ADHD
- ☐ Allergies
- ☐ Autism
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Gastric Reflux
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Hypothyroid
- ☐ Speech Disorder
- ☐ Chicken Pox
- ☐ Meningitis
- ☐ Smoking
- ☐ COVID-19
- ☐ Other: _____

Past Surgical History (with date included)

- ☐ No Past Surgical History
- ☐ Tonsillectomy: _____
- ☐ Adenoidectomy: _____
- ☐ Appendectomy: _____
- ☐ Ear Tubes: _____
- ☐ Incision and Drainage: _____
- ☐ Previous Hospitalization: _____
- ☐ Other: _____

If you answered yes to any of the above questions, please explain below:

_____

_____

_____

_____

_____

_____

Family History (Please label below with : **M** for Mother, **F** for Father, **S** for Sibling, and **G** for Grandparent.)

- ☐ Anxiety
- ☐ Asthma
- ☐ Congenital Heart Defect
- ☐ Cardiomyopathy
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/Seizures
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Sickle Cell Anemia
- ☐ Unknown
- ☐ Unexpected or unexplained death before the age of 35 years?

Who is your child's Primary Care Physician? _____ City: _____ Phone: _____

What pharmacy do you use? _____ City: _____ Phone: _____

Does your child currently take any medications? Yes No

Please list any medications with current dose (how much and how often):

_____

_____

Emergency medication kept at school? Yes No _____

Is your child allergic to any medications? Yes No _____

Is your child allergic to environmental factors (bees, latex, nuts, food, etc.)? Yes No

Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.): Yes No

Name of Allergen	*Type of Reaction*
_____	_____
_____	_____

Who is your child's dentist? _____ City: _____ Phone: _____

SERVICES OFFERED

Please read carefully, COMPLETE FORM, SIGN, and DATE. Your Child should return this form to their homeroom teacher. Please notify A Plus KidCare Clinic if there are any health changes or a change in guardianship. Consent will remain in effect until the end of the school year or at which time A Plus KidCare Clinic is notified in writing that you wish to revoke such.

I give my consent for _____ _____ _____

Child's Full Name ***Birth Date*** ***Social Security Number***

to receive the following services at A Plus KidCare (PLEASE INITIAL):

**KidCare may supply a limited amount of over the counter medication that will only be given if ordered by an A Plus Family HealthCare provider for services rendered same day.

_____ **I give permission for over the counter medication ordered by an A Plus Family KidCare provider to be administered to my child at the time of their visit.**

_____ ***Nurse Practitioner/Physician Assistant/Telehealth Services*. You will *be contacted prior to the exam, please initial***
(NP/PA/Telehealth services for acute illness, wellness exams, CLIA waived testing, sports physicals, etc.)

_____ **W*ell Child Exam* (Yearly physical to assess height, weight, vision, hearing, anticipatory guidance, etc.). You will *be contacted prior to the exam*. Date of Last Well Child Exam: _____**

_____ **Influenza Vaccine (Yearly vaccine to prevent against the annual influenza) Please note that a separate consent form is required for this service.**

_____ **No Services at this time.**

PLEASE READ AND INITIAL BELOW:

_____ I acknowledge that once my child reaches the age of 18, they must sign a seperate consent giving permission for A Plus KidCare Staff to communicate any health or billing related information with me.

SIGNATURE REQUIRED:

I acknowledge that by signing below, I am giving consent for my child to receive the services listed above at A Plus KidCare.

_____ _____ _____

Parent/Guardian Signature ***Print Name*** ***Date***

_____ _____ _____

Patient Signature (if 18 years or older) ***Print Name*** ***Date***

Assignments and Authorizations

Patient Name: _____ **Date of Birth:** _ _ /_ _ / _ _ _ _

My signature below attests that I am the the below terms.

- ☐ **Biological/Adoptive Parent** for the patient named above and my agreement of
- ☐ **Legal Guardian; or**
- ☐ **Foster Parent***

In order to protect the welfare of the patient, if any court orders/decrees/letters/contracts authorizing medical treatment exist regarding custodial/parental/guardian rights, etc., please be aware that we must maintain a copy of these documents in the patient's file.

I understand that I may be subject to legal ramifications if I purposely provide false or inaccurate information to A Plus Family HealthCare Clinics. This release expires one (1) year from the date of signature; unless I choose to revoke this agreement (termination of the authorization must be received in writing).

On behalf of my minor child or other patient named above,

CONSENT TO TREAT

I hereby give my permission to A Plus Family HealthCare (referred to as "APFHC" in this form) for the evaluation and treatment of the presented medical and/or behavioral health condition (herein referred to as "health care services"). I am requesting that health care services be provided to my minor child or the patient named above at APFHC. I voluntarily consent to all treatment and health care services that the caregivers at APFHC consider to be necessary for the patient named above. These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell the APFHC caregiver. My minor child or other above-named patient's blood may be used to perform routine quality assurance testing. APFHC complies with all laws allowing minors to consent for treatment without parental consent. I am aware that the practice of medicine and behavioral health are not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

FINANCIAL RESPONSIBILITY

Subject to applicable law and the terms and conditions of any applicable contract between APFHC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay APFHC for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay APFHC for the patient balances due.

ASSIGNMENT OF BENEFIT

In consideration of all health care services rendered or about to be rendered to the above-named patient, I hereby assign to APFHC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding APFHC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by APFHC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with APFHC for my insurance to be billed and as such I will be asked to present my insurance card at each visit to verify my insurance coverage. If I do not provide APFHC with accurate insurance information I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient of APFHC, I authorize APFHC to retrieve and use my minor child or other above-named patient's medication history from SureScripts, an electronic prescriptions network. This is an electronic way for APFHC to access patient prescription benefit information and patient medication history. APFHC can only retrieve medication history from offices/pharmacies that support SureScripts. Utilizing this method is the best way to obtain the most up to date information so that the healthcare provider can deliver the best care to your minor child or other named patient above.

I also authorize APFHC to utilize interface exchanges to retrieve historical medical information from lab companies, hospitals, and

Assignments and Authorizations

other medical providers to meet routine quality guidelines and continuity of care (including but not limited to recent or historical diagnostic imaging reports, cervical cancer screenings, HIV screenings, Hemoglobin A1C testing, medical hospitalizations, immunization records,etc).

PHOTO CONSENT AND RELEASE

I consent to have photos of my treatment and/or treated areas to be used for the process of monitoring my healing progress. I understand that these photos will be used for my chart only but may be released for the purpose of referral to a specialist for treatment of my condition.

NOTICE OF PRIVACY PRACTICE

I have received a copy of the APFHC Notice of Privacy Practices. The Notice of Privacy Practices explains how APFHC may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let APFHC use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by APFHC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent APFHC or provide assistance to APFHC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above named patient's) health care, including for substance use, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that APFHC has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to APFHC or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from APFHC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered, including marketing messages/calls. I understand this consent to communications is not required to receive services from APFHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

FOR BIOLOGICAL/ADOPTIVE PARENTS ONLY

You may list in the space provided below, individuals who are given permission to consent for treatment for the patient listed above and have the same access to the patient's medical records, including the right to disclose the contents to others:

Authorized Individuals:	Relationship to Patient:	Phone Number
_____	_____	_____
_____	_____	_____

FOR MINOR PATIENTS 16 YEARS OF AGE OR OLDER

☐ I authorize the minor patient referenced above to seek care and treatment, including vaccinations, without a parent/guardian present (except for sports or school physicals).

_____ Patient/Legal Guardian Signature

_____ Relationship to Patient

_____ Telephone Number

_____ Date

_____ Witness Signature

_____ Date

*Foster parents are exempt from Consent to Treat, Financial Responsibility, and Assignment of Benefit when care is provided while child is in custody of DCBS as outlined in the DPP – 106A Form by the Cabinet for Health and Family Services.