LA CLINICA
SCHOOL-BASED HEALTH CENTERS

If you or anyone in your family need support with any of these services, please check all that apply.

Student's name: _____ Date: _____

Parent/Guardian name: _____

PH Number or best way to contact: _____

Person(s) referring: _____

Referral Checklist:

- [ ] Housing/Shelter [ ] Social Support [ ] Legal Assistance
- [ ] Health Insurance (OHP) [ ] Food [ ] Addiction/Recovery
- [ ] Health Care (Medical, Dental, Vision) [ ] Transportation [ ] Childcare
- [ ] Counseling/Therapy/Behavioral Health [ ] Safety/Advocacy [ ] Supplies (Clothing, etc.)
- [ ] Other: _____
- Family Stress: ☐ Low ☐ Medium ☐ High

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

Si usted o alguien en su familia necesita algunos de estos servicios por favor marque todos los que apliquen.

Nombre del estudiante: _____ Fecha: _____

Nombre del Padre/Guardian Legal: _____

Número de teléfono o mejor forma de ser contactado: _____

Nombre de la persona refiriendo: _____

Lista de cotejo para referido:

- [ ] Vivienda/Albergue [ ] Apoyo Social [ ] Asistencia Legal
- [ ] Seguro de Salud (OHP) [ ] Alimentos [ ] Adicción / Recuperación
- [ ] Atención médica (médica, dental, de la vista) [ ] Transporte [ ] Cuidado de los niños
- [ ] Consejería/Terapia/Salud conductual [ ] Seguridad /Defensa [ ] Suministros (ropa, etc.)
- [ ] Otros: _____
- Estrés familiar: ☐ Bajo ☐ Mediano ☐ Alto

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

Dear Families,

The School Based Health Center is here to support students during school hours. Having parental consent on file for each student makes it possible for our Nurse or Nurse Practitioner to assess and treat illness or injury that occurs during the school day. Parent or Guardian will be contacted if more immediate attention is necessary at the time of visit. The benefit of us doing this is that we may be able to help students ease minor aches and pains allowing them to stay in school as much as possible.

Our services offer a continuation of care and do not replace any Primary Provider that your child may already have.

We want to thank you for taking the time to complete all the health center forms, highlighted areas on the paperwork are important and commonly missed items. We hope your student has a healthy and happy school year.

Thank You,

La Clinica SBHC Staff

"HEALTHY KIDS LEARN BETTER"
Improving the health and well-being of children is important to us and remember NO ONE IS TURNED AWAY FOR INABILITY TO PAY.

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

Estimadas Familias,

Estamos entusiasmados por la oportunidad de asistir con las necesidades de salud de los estudiantes durante el año escolar. El centro de salud en la escuela está aquí para apoyar a los estudiantes durante las horas escolares. Tener los documentos de consentimiento de los padres para cada estudiante hace posible que nuestra enfermera o proveedora médica pueda evaluar y tratar cualquier enfermedad o lesión que se produzca durante el día escolar.
Los Padres o tutores serán contactados si se necesita atención más inmediata en el momento de la visita. El beneficio de hacer esto es que podremos ayudar a los estudiantes aliviar dolores menores para que les permita permanecer en la escuela tanto como sea posible.

Nuestros servicios ofrecen la continuidad de atención médica y no reemplace el proveedor primario de su hijo/a.

Queremos agradecerles por tomarse el tiempo para completar todas las formas para el centro de salud, áreas resaltadas con marcador son importantes y comúnmente dejadas sin llenar. Esperamos que su estudiante tenga un año escolar saludable y feliz.

Gracias,

La Clinica Centro de Salud Escolar SBHC

"NIÑOS SANOS APRENDEN MEJOR"
Mejorar la salud y el bienestar de los niños es importante para nosotros y recuerde nadie es rechazado POR INCAPACIDAD DE PAGAR.

Teacher: Grade:	LA CLINICA SCHOOL-BASED HEALTH CENTERS	MRN: PCP:

School-Based Health Services Consent Form

We want to work with you to improve your child's health and are happy to work with your primary doctor or nurse practitioner. Our goal is to make sure your child's healthcare needs are met. We want your child to be cared for when it is needed so they can be as healthy as possible.

Please consent to the following services by checking yes or no and initialing:

- Over-the-counter medications for symptom relief ☐ Yes ☐ No Parent or guardian initials _____

List known allergies (medications/foods/other) and reactions: _____

_____

Payment
I understand I am ultimately financially responsible for the services I receive. Virtual visits have the same fees as in-person treatment. Some insurers may not cover these visits. I will check with my insurer before a virtual visit if I need information about co-pays or fees. If I have an insurer, I direct the insurer to pay La Clinica for service. I authorize the release of healthcare records as outlined in La Clinica's Notice of Privacy Practices.

Right to Get a Good Faith Estimate
I have received a copy of La Clinica's notice about my right to get an estimate of healthcare costs.

Notice of Privacy Practices
I have received a link to a copy of La Clinica's Notice of Privacy Practices. I know I can ask for a printed copy at any time.

Patient Rights and Responsibilities
I have received a link to a copy of La Clinica's Patient Rights and Responsibilities. I know I can ask for a printed copy at any time.

Communication Options

- La Clinica texts appointment reminders and other messages about my care if I have provided a mobile phone number. I also authorize La Clinica to text me newsletters and messages about other services. _____ Initial
- I give La Clinica permission to send unencrypted email or text messages to me about services. _____ Initial

These communication choices will stay in effect until I ask to change them.

In La Clinica's school-based health services, protected information will be used or shared only when needed. The purpose must be related to the child's health, well-being, and ability to learn and succeed. _____ Initial

Before your child gets care, we ask you to give permission for treatment. In-person and virtual services may include a medical provider or registered nurse. A registered nurse employed by the school district may work with the La Clinica team during virtual visits. All services are not available at all schools. Any student can be seen at any La Clinica School-Based Health Center.

By signing this form, I give permission for _____ _____ to receive
Student's full name *Date of Birth*
the above services at La Clinica's school-based health centers.

_____ _____

Parent or Guardian Printed Name *Relationship to Patient*

_____ _____

Parent or Guardian Signature *Date*

La Clinica School-Based Health Centers provides primary and preventive medical care for students in collaboration with school districts and community partners. (Policies available upon request). The dental health screening provided through this program is a brief visual exam and does not take the place of a complete dental exam by a dentist. La Clinica provides these dental services with support from the Walker Fund and contributions by Oral Health America.

Student Name:
DOB:
School:
Teacher:
Grade:

MRN:	PCP:

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

Patient Questionnaire

1. Does your child have a doctor or family nurse practitioner he or she sees regularly? ☐ Yes ☐ No

   If yes, name of Doctor/Nurse Practitioner: _____

   Approximate Date of last well child exam: _____

2. Preferred Pharmacy: _____
3. Does your child have any allergies? ☐ Yes, (list) _____ ☐ No allergies
4. What medications does your child take regularly? Please include over the counter medications, supplements, and inhalers: _____ ☐ None
5. Does your child have any behaviors that may impact our ability to provide care to him/her? ☐ No

   ☐ Yes: _____
6. History of other medical problems: _____ ☐ None
7. Does your child have a dentist he/she sees regularly? ☐ Yes ☐ No

   If yes, name of Dentist: _____

   Approximate Date of last dental exam: _____

Signature _____ Print name _____Date_____

Relationship to child_____

La Clinica School-Based Health Centers provides primary and preventive medical care for students as agreed by its partners: La Clinica, Asante Health System, Providence Medford Medical Center, Medford School District 549C, Central Point School District #6 and Phoenix/Talent School District #4 (policies available upon request).

LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

SCHOOL-BASED HEALTH SERVICES
541-414-1575
www.laclinicahealth.org/school

MRN:	INS:	Date:
Teacher:		Grade:

La Clinica receives support from the government to help patients and participants who qualify cover the cost of services. As a result, we are required to collect income and household information from everyone who uses our services. Our privacy protection policies require us to keep your personal information private.

La Clinica School-Based Health Centers provides primary and preventive medical care for students in collaboration with school districts and community partners. (Policies available upon request). The dental health screening provided through this program is a brief visual exam and does not take the place of a complete dental exam by a dentist. La Clinica provides these dental services with support from the Walker Fund and contributions by Oral Health America.

Patient's Full Name:	DOB:	SSN:
Parent/Guardian Name: DOB:	Relationship to patient:	
Address:	City:	ZIP Code:

Home Phone:	Cell Phone:	Work Phone:	Name of Employer:	Full-Time / Part Time (circle one)

Emergency contact/phone number:	May we leave you messages with health information? ❑ Yes ❑ No

Are you and your family members living in someone else's household? (*includes couch surfing*)	❑ Yes ❑ No	**#3**
In the past 2 years, have you or someone in your household lived in one of the following: foster care, motel, shelter, group home, recovery center, or jail?	❑ Yes ❑ No	**#2**
In the past 2 years, have you and your family been forced to move into a temporary situation because of housing costs?	❑ Yes ❑ No	**#7**
Are you and your family members living in one of the following: camp, street, bridge, shelter?	❑ Yes ❑ No	**#4**
Are you and your family members currently not homeless, but were in the last 12 months?	❑ Yes ❑ No	**#5**
Are you and your family members living in public housing?	❑ Yes ❑ No	
Have you or anyone in your household worked in any of the following industries: crops/harvesting, farming, ranching, packing house, aquaculture, orchards, reforestation, vineyards?	❑ Yes ❑ No	
If yes: 1) Did you work in the industry in the past two years?	❑ Yes ❑ No	
2) Did your family ever move to accommodate your work?	❑ Yes ❑ No	
3) Have you or a member of your household ever had to stop working in this field due to a disability?	❑ Yes ❑ No	

Patient's Race: *(Check all that apply)*
❑ Alaskan Native ❑ American Indian ❑ Black/African American
❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean
❑ Vietnamese ❑ Other Asian ❑ Native Hawaiian ❑ Chamorro
❑ Guamanian ❑ Samoan ❑ Other Pacific Islander ❑ White
❑ Unknown ❑ Choose not to disclose

Patient's ethnicity:
❑ Hispanic ❑ Mexican ❑ Mexican American
❑ Chicano ❑ Cuban ❑ Puerto Rican ❑ Not Hispanic
❑ Unknown ❑ Choose not to disclose

Is the patient disabled? ❑ Yes ❑ No

*** Please complete this form entirely. Incomplete forms will not be accepted.**
If you have Insurance, we will bill it for eligible services.

LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

Patient Name: _____

MRN:_____PCP/PCD:_____

Responsible Party and Billing Information

La Clinica gets support from the government to help patients who qualify cover the cost of services. Income guidelines are set annually by the federal government. Even if you choose not to apply, we are required to ask for some financial information about everyone served at our health centers. We will keep all personal information private as outlined in our Notice of Privacy Practices.

Part 1: Responsible party—If you or an immediate family member already have an account with La Clinica, please provide the information of that account holder.		
☐ The responsible party is the same as the patient registering for services.		
Legal guardian/parent name:	Date of birth:	Social Security #:
Mailing address: *(Include city, state, zip code.)*		
Home phone #	Cell phone #	Email:

Part 2: Tell us about your insurance. We bill all insurance provided to us. Please check with your insurance regarding contracts with our facility and any out-of-pocket expenses.	
Insurance name:	Claim address:
Name of primary insured:	Date of birth: Relationship to patient:
Subscriber/member ID:	Group #:

Part 3: Tell us about your financial situation. You may be eligible for grant support to cover the cost of services.	
Annual household income:	Family size:
☐ I want to apply for financial assistance.	☐ I do <u>not</u> want to apply for financial assistance.

Billing disclosure:
I understand that if I choose not to disclose my income or provide my insurance information I will be billed for all services rendered.

Responsible party signature:	Date:
Printed name:	

For Staff Use Only: Income verified in chart #_____ Staff Name: _____

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (REALD)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (*if applicable*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

_____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: **Agency staff or provider name or ID:**

Phone: **Address:**

Continued on next page

Print Save Reset

Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

Skip to question 7 if you indicated English only

4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Other ***(please list)***: _____
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ Contact sign language (PSE) interpreter

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)		Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?						
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?						
	Please stop now if you/the person is under age 5						
9.	Do you have **serious difficulty walking or climbing stairs**?						
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?						
11.	Do you have **difficulty dressing or bathing**?						
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?						
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?						
	Please stop now if you/the person is under age 15						
14.	Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?						
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?						

Print Save Reset

Your right to get an estimate of healthcare costs

If you don't have health insurance or aren't using insurance, La Clinica must give you an estimate of the bill before you get care. This is called a "good faith estimate." It is required by law.

Here's what you need to know about this estimate of how much your health care will cost.

- You have the right to get a good faith estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, dental services, equipment, and hospital fees.
- For appointments set 3 or more days in advance, your healthcare provider must give you a written estimate at least 1 business day before you get care. You also can ask La Clinica or any provider you choose for an estimate before you schedule care.
- If you get a bill that is more than $400 over your good faith estimate, you can dispute the bill.
- Make sure to save a copy or picture of your good faith estimate.

For questions or more information about your right to a good faith estimate, visit www.cms.gov/nosurprises or call our billing department at 541-535-6239.

Su derecho a obtener un estimado de los costos de cuidado de salud

Si no tiene seguro médico o no está usando un seguro, La Clinica tiene que darle un estimado de la factura antes de recibir cuidado médico. Esto se llama una "estimado de buena fe". Es requerido por ley.

Esto es lo que necesita saber sobre el estimado de cuánto costará su cuidado de salud.

- Usted tiene el derecho de recibir un estimado de buena fe para el costo total anticipado de cualquier artículo o servicio que no sea de emergencia. Esto incluye costos relacionados como pruebas médicas, medicamentos recetados, servicios dentales, equipos y tarifas hospitalizarías.
- Para las citas programadas con 3 o más días de anticipación, su proveedor de cuidado de salud debe darle un presupuesto por escrito al menos 1 día de trabajo antes de recibir cuidado médico. También puede preguntarle a La Clinica o a cualquier proveedor que elija por un estimado antes de una cita de cuidado médico.
- Si recibe una factura que es más de $400 sobre el estimado de buena fe, puede disputar la factura.
- Asegúrese de guardar una copia o imagen de su estimado de buena fe.

Para preguntas o más información sobre su derecho a un estimado de buena fe, visite www.cms.gov/nosurprises o llame a nuestro departamento de facturación al 541-535-6239.

LA CLINICA

Scan this code to read La Clinica’s Notice of Privacy Practices in English.

https://laclinicahealth.org/privacy

Escanee este código para leer el aviso de prácticas de privacidad de La Clínica en español.

https://laclinicahealth.org/privacidad

Scan this code to read La Clinica's Patient Rights and Responsibilities in English.

https://laclinicahealth.org/rights

Escanee este código para leer los derechos y responsabilidades del paciente de La Clínica en español.

https://laclinicahealth.org/derechos

You can get these documents in other languages, printed, large print, or braille. Email communications@laclinicahealth.org or call 541-512-3114.

Puede obtener estos documentos en otros idiomas, impresos, en letra grande o en braille. Envie un correo electrónico a communications@laclinicahealth.org g o llame al 541-512-3114.