WMC PHYSICIAN PRACTICES LLC

ENROLLMENT AND CONSENT FORM

Patient Name: _____ SSN #: _____

Address: _____ City: _____ State/Zip: _____

Phone: _____ Grade: _____ Birth date: _____ School: _____

Lives With: ____ Mother _____ Father _____ Both _____ Other: _____

Gender: Female or Male Ethnicity *(please circle one)* Hispanic Not Hispanic Unknown Decline

Race *(please circle one)* White Black/African American Asian American Indian Pacific Islander Other

PARENT / GUARDIAN CONTACT INFORMATION

Father: _____ Phone (H) _____ (W) _____

(Cell) _____ Email: _____

Mother: _____ Phone (H) _____ (W) _____

(Cell) _____ Email: _____

Guardian: _____ Phone (H) _____ (W) _____

(Cell) _____ Email: _____

Alternate Contact: _____ Phone (H) _____ (W) _____

(Cell) _____ Email: _____

Patient's Insurance Coverage

Primary Health Insurance:

Name of Insured Parent / Guardian _____

Birth date of Card Holder _____

Address (if different from child _____

Place of Employment _____

Name of Insurance Company _____

Insurance Address _____

Insurance Phone / Fax Number _____

Group & ID Number _____

Secondary Health Insurance:

Name of Insured Parent / Guardian _____

Birth date of Card Holder _____

Name of Insurance Company _____

Insurance Address _____

Insurance Phone / Fax Number _____

Group & ID Number _____

Medicaid: *(please circle one)* Unicare Carelink Other:

Medicaid ID#: _____ Member ID# (Carelink) _____

PCP/HMO Provider: _____ Provider Phone Number: _____

CHIP: Name on Card: _____ Birth date of Card Holder: _____

ID or PIN # on Card: _____ Group #: _____

No **health insurance /** Request application for sliding fee/ CHIP / Medicaid

Patient's Health Information

1. Please list any allergies, medications, chronic illnesses, or surgeries your child has/has had:

_____

_____

2. Doctor's name / phone number: _____
3. Would you like us to provide your child's Well-Child Exam (physical) this year? Yes _____ No _____
4. When was your child's last dental exam? _____ Name of Dentist: _____
5. Immunizations: Please attach a copy of your child's immunization record.

NOTICE OF PRIVACY

The Health Insurance Portability and Accountability Act (HIPPA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed and how a patient may obtain access to their personal health information. I may obtain a copy of the Privacy Practices by contacting the WMC Physician Practices, LLC at (304) 797-6200.

_____ _____

Signature of Patient/ Parent or Guardian Date

CONSENT TO TREAT

I agree for my child or myself to receive health care at the Allison Elementary School. I understand that this consent form will be in effect until my child leaves the school or until I tell WMC Physician Practices, LLC, staff, I do not want my child to receive care any longer.

By signing this form, I am giving WMC Physician Practices, LLC, the school nurse and my child's regular doctor (if she or he has a regular doctor) permission to talk about and share medical information about my child. I understand that this information will always be kept confidential. Health information shared between the student, parents and WMC Physician Practices, LLC, will be kept private. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents or guardians. The staff will encourage every student to involve his or her parent or guardian in health care decisions.

No student will be denied access to health care services due to inability to pay. As in any health care center, there may be a charge depending on the service given. We will bill the patient's insurance or Medicaid, when available. WMC Physician Practices, LLC, may release information regarding treatment to third party payers for billing purposes. I understand that if guardianship changes, a new consent must be signed by the legal guardian. If I cannot be reached, medical information regarding the above child will be shared between the medical provider and the other contact.

_____ _____

Signature of Patient/ Parent or Guardian Date