

Enrollment Form - School Based Health Clinic



☐ Lamesa ISD South Elementary ☐ Lamesa ISD North Elementary

Grade/Campus _____

Student/Patient Information

Name: (First)_____ (Last)_____ (Middle Initial)____ DOB _____

☐ Male ☐ Female Allergies _____

Primary Care Provider/Pediatrician _____

Health Concerns? _____

Parent/Guardian/Responsible Party

1. Name: (First)_____ (Last) _____ DOB _____

Mailing Address: _____ City/State _____ Zip _____

Telephone Number: Home _____ Cell _____

2. Name: (First)_____ (Last) _____ DOB _____

Mailing Address: _____ City/State _____ Zip _____

Telephone Number: Home _____ Cell _____

Email _____

Insurance Carrier: _____ Group Number _____

Subscriber Name: _____ Subscriber Date of Birth _____

Member #/ID _____

Acknowledgements:

_____ I have been informed of the HIPAA and Privacy Practices and Patient Rights and Responsibilities.

_____ I agree to notify Medical Arts Health Clinic if my insurance provider changes during the Enrollment period of the school year.

_____ I acknowledge that my child may see a provider other than their primary care provider.

Return Registration form along with photocopy of Insurance Card and Photo ID to:

Medical Arts Health Clinic – Attention Registration

2202 North Bryan Avenue

Lamesa, Texas 79331

Email - rhcreg@medicalartshospital.org



MEDICAL ARTS HEALTH CLINIC - SCHOOL BASED CLINIC

2202 North Bryan Avenue
Lamesa, Texas 79331
(806) 872-7291 • (806) 872-1130 Fax
A Service of Dawson County Hospital District dba Medical Arts Hospital

Consent for Treatment

I understand that if medical treatment is necessary, a physician, nurse practitioner, physician assistant, or other appropriate healthcare provider of the Medical Arts Health Clinic will perform such medical treatment and procedures via a telehealth visit while the patient (student) is on the school campus.

I understand that Nurse Practitioners (NP) and Physician Assistants (PA) are not physicians, but do function under the supervision of a physician, either directly or via protocols established by a physician and that NP's and PA's are formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. I also understand that as working as members of the health care team, NP's, and PA's take medical histories, examine patients, order and interpret laboratory tests and x-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting.

Providers record progress notes, instruct and counsel patients, order or carry out therapy, or perform minor invasive procedures.

Medicare/Medicaid Patient's Certification: Authorization to release information and payment request. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits: I hereby authorize payment directly to Medical Arts Health Clinic of healthcare benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to Medical Arts Health Clinic and provider for charges not covered by this assignment.

Authorization for Release of Medical Information: The clinic and providers are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency, which may be assisting in payment for my care.

Refund of Insurance Benefits: I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverages are subject to a coordination of benefits clause.

I have read and fully understand the above Acknowledgement for Treatment and hereby grant my authorization and consent for such treatment and procedures while enrolled in the school based health program with Medical Arts Health Clinic.

Patient/Student Name: _____

Parent/Legal Guardian Signature _____

(Guardian signature required if patient is younger than 18 or legal guardianship has been ordered)

Date: _____ Time: _____

Witness Signature: _____