School Based Health Center Services Include:

Primary Health Care
Immunizations • Annual & Sports Physicals • Sick Visits

Dental Care
Dental Cleanings & Visual Oral Exam
Flouride Application Dental
Sealants (if needed) Restorative
Care (fillings) if needed

Behavioral Health Services
Anxiety • Bullying • Depression

Mobile Office
Primary Care & Dental Services

Our Mobile Office visits most schools in East Hartford, Manchester, Vernon and select CREC Schools.

Both of your yearly dental visits and annual physical can be provided at our School Based Health Centers or Mobile Office.

We accept most insurances. Uninsured? Sliding Fee and Insurance Eligibility Applications Available!

Call Us TODAY to Schedule an Appointment!

860-610-6183

First Choice Health Centers
For All Your Health Care Needs

LOCATIONS & SERVICES:

East Hartford
92 Connecticut Blvd: Behavioral Health
94 Connecticut Blvd: Dental, Primary Care & Substance Abuse
110 Connecticut Blvd: Pediatrics, OB/GYN
809 Main St: Primary Care, Optometry & Podiatry
265 Ellington Rd: Primary Care & Behavioral Health

Manchester
150 N. Main St: Primary Care, Dental, Podiatry & Behavioral Health
444 Center St: Primary Care
Cheney Tech High School: Primary Care & Behavioral Health
Illing Middle School: Primary Care & Behavioral Health

Vernon
94 Union St: Primary Care & Behavioral Health
3 Prospect St: Dental
Rockville High School: Primary Care & Behavioral Health

Our School Based Health Centers (listed in blue) are for the exclusive use of students and their immediate family members living in the same household.

First Choice Health Centers' mission as a community health center providing integrated care is to break down the social and economic barriers to wellness and healthy living while extending the viable and productive lives of those we serve.

ALL PUBLIC SCHOOL STUDENTS ARE ELIGIBLE

First Choice Health Centers
For All Your Health Care Needs

School Based Health Center

Medical • Dental • Behavioral Health

We are pleased to offer high quality, affordable healthcare services at your child's school!

Parents do not need to miss work and your child does not need to miss school for routine care.

ADVOCACY CENTER OF EXCELLENCE

SIGN UP TODAY!

Fill out and return this form to your school nurse to ensure a healthy school year!

First Choice Health Centers
For All Your Health Care Needs

School Based Health & Dental Program

Registration and Consent form

School Name: _____ **Grade:**_____

Dear Parent or Guardian: Our School Based Healthcare Program is pleased to provide the following services at your child's school during school hours: dental cleaning, fluoride treatment, oral health education, sealant placement & restorative care (if needed), medical and behavioral health services. Please fill out this form and return to the school nurse to enroll your child in the program. Questions? Call our Coordinator at 860-528-1359 x183

Student Information

Last Name | First Name | MI | Date of Birth

Street Address | City | State | Zip

Public Housing ☐ Homeless ☐ If yes, please specify: Shelter ☐ Street ☐ Doubling Up ☐ Transitional ☐ Other ☐

Home Phone	Cell Phone	Work Phone	Emergency Contact Person	Emergency Contact Telephone

Sex: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity: ☐ Hispanic/ Latino ☐ Non-Hispanic/Latino

Race: ☐ Black/African-American ☐ American Indian/Alaskan Native ☐ Pacific Islander ☐ Native Hawaiian ☐ Caucasian ☐ Asian ☐ Other Pacific Native ☐ Other: _____

Parent/Guardian Name | Parent/Guardian Date of Birth

Insurance Infor-

Primary Dental Insurance | Insurance ID/Medicaid ID # | Group #

Policy Holder's Name | Policy Holder's Date of Birth | Policy Holder's Social Security #

Primary Medical Insurance | Insurance ID/Medicaid ID # | Group #

Policy Holder's Name | Policy Holder's Date of Birth | Policy Holder's Social Security #

Income

My Annual Income is: _____ Total # of Dependents in Household (including patient): _____

Last Dental Visit

Does your child have a primary dentist?

Name: _____ Phone: _____

Permission for Treatment, Payment and Operations

I give permission for my child to receive medical, dental, and behavioral health treatment services by First Choice Health Centers, Inc. **I understand that this authorization is valid as long as my child is enrolled in the school district listed above** or until I revoke this authorization with the Program Coordinator at First Choice. I hereby authorize First Choice to use and disclose my child's medical/dental information for treatment, payment and healthcare operation purposes. My consent includes the release of such information to process claims to my insurance company. I authorize direct payment from my insurance company to First Choice. I also allow disclosure of protected health information to the school nurse as appropriate. I consent to receiving phone calls regarding services my child receives or may be eligible to receive. I acknowledge that I have received a copy of the Notice for Privacy Practices for First Choice Health Centers, Inc., which further explains how First Choice may use and disclose my child's Protected Health Information. By signing this consent form I certify I am the legal guardian and legal custodian of the student named above. I have read and understand the above and agree with the above paragraph and certify that all the information provided is true and correct.

To better provide care, Provider seeks to coordinate integrated delivery through the electronic health record, which is paperless. The information is shared across provider locations and may be shared with some other affiliates through a health information exchange. Provider uses a system that allows electronic prescribing of medications. I authorize Provider to request and use my child's prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

By signing this form, I understand and agree that I am allowing disclosure and access to all my child's health information, including information related to alcohol and substance abuse/use, mental or behavioral health, medication prescription history, and HIV/AIDS. **I understand if I do not want my information stored in the electronic health record (which may be shared through health information exchanges), and utilized in my care, I will not be able to receive care with Provider, and have the right to opt out of receiving care at any time.**

Parent's Signature: _____ Date: _____

I certify and attest that all of the above information is true and correct. I understand that FCHC may verify information on this form. I understand that the financial information will determine eligibility for the center's sliding fee discount. I also understand that if I intentionally misrepresent my family's income, my child will not be eligible to receive services at a discount rate. I also understand that I will be financially responsible for all charges incurred should insurance not cover the services.

Parent's Signature _____ Date _____