ATCHISON COMMUNITY HEALTH CLINIC
The Everybody Clinic

Behavioral Health Care Program by ACHC @ USD #430

Your child's school has agreed to work with the Atchison Community Health Clinic to provide space for behavioral health services. ACHC will be offering behavioral health services in your child's school. ACHC will communicate with parents regarding treatment progress, goals, and objectives. The Atchison Community Health Clinic provides this service.

School Location:	**Horton High School**	**Childs Name:**			
	Everest Middle School	**SOCIAL SECURITY NUMBER:**			
		DOB:		**SEX AT BIRTH**	
Other:		**SEXUAL ORIENTATION/GENDER IDENTITY**	_____ ◯ **CHOOSE NOT TO ANSWER**		

Street Address:	**City:**	**State:**	**Zip Code:**
Parent/Guardian Name:	**City:**	**State:**	
Student Insurance Name and Member ID #		**Phone Number:**	
Language:			
Race:	**American Indian** ◯ **Asian** ◯ **Native Hawaiian or Other Pacific Islander** ◯ **Black or African American** ◯ **White** ◯ **Other Race** _____		
Ethnicity:	**Hispanic or Latino** ◯ **Not Hispanic or Latino** ◯		

Emergency Contact		
Name:	**Phone:**	**Relationship:**
Address:	**City:**	**Zip Code:**

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BEHAVIORAL HEALTH HISTORY
Previous/Current Mental Health Services (Inpatient or Outpatient) and services dates:
Medication your child is currently taking for mental health purposes: (Name, Dose, Prescribing Provider)

****Please note, the federal government requires us to ask you for the following information. It is used for government reporting purposes only. No identifying information will ever be disclosed, including name, and we will not use this information for any other purpose.****
PLEASE CIRCLE YOUR FAMILY SIZE AND THE RANGE OF YOUR ANNUAL INCOME.

2018 ANNUAL FEDERAL POVERTY GUIDELINES

FAMILY SIZE				
1	$0.00 - $12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981 +
2	$0.00 - $16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821 +
3	$0.00 - $21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661 +
4	$0.00 - $25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501 +
5	$0.00 - $30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341 +
6	$0.00 - $34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181 +
7	$0.00 - $39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021 +
8	$0.00 - $43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861 +

ACHC will treat all patient information as protected health information (PHI) under HIPAA regulations, exchanging the PHI only with necessary ACHC personnel, and those allowed by written consent from the parent/guardian.

CONSENT:
I give the Atchison Community Health Clinic (ACHC) permission to provide behavioral health services to my child. I acknowledge that the Privacy Practices were and are available for my review. This consent is valid for one year from the Parent/Guardian Signature date below. I authorize Atchison Community Health Clinic to submit all services to my insurance company and to collect payment on my behalf. I understand that I am responsible for any copay or deductible amounts.
Parent/Guardian Name:
Parent/Guardian Signature:
Date:

ATCHISON COMMUNITY HEALTH CLINIC

1412 North 2nd Street
Atchison, Kansas 66002
Phone: 913-367-4879
Fax: 913-367-0240
www.achc-ks.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Last Name: _____Patient First Name: _____

Date of Birth_____ Social Security Number_____-_____-_____Phone #:_____

Patient Address/City/Zip_____

I request and authorize the release of my behavioral health medical record between Atchison Community Health Clinic and the school named below:

Name of School:_____

School Address:_____

School Phone #:_____

School Fax#:_____

This release of information allows disclosure of the following from ACHC (please initial):

	BEHAVIORAL HEALTH DIAGNOSIS		MEDICATION LOGS
	TREATMENT PLAN AND GOALS		PROGRESS NOTES
	DATES OF SERVICE		SUMMARY OF TREATMENT

This release of information allows disclosure of the following from the school specified above (please initial):

	INDIVIDUALIZED EDUCATION PLAN		BEHAVIOR PLAN
	SCHOOL RECORDS AND REPORTS		OTHER:

Type of Disclosure allowed between ACHC and designated school (please initial):

	WRITTEN		FAX		VERBAL		TELEPHONE

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that treatment is not conditioned upon the execution of this authorization. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize Atchison Community Health Clinic to use and disclose the information as specified above.

I understand that I may revoke this authorization at any time by mailing or hand delivering written notification to the following person: Executive Director, ACHC, PO Box 27, Atchison, Kansas 66002

Patient/Parent/Legal Guardian Signature_____Date_____

If the person giving this authorization is acting as the patient's personal representative, complete the information below:

Personal Representative's Signature _____

Printed Name of Representative_____

Representative's Address _____

Representative's Telephone Number_____

Relationship to Patient (please initial one)

_____ I am the parent or legal guardian of the minor patient who lacks legal authority to consent to his/her own medical treatment.

_____ I have been given authority by a court of proper jurisdiction to act on the patient's behalf, including execution of this authorization.

_____ I have been formally appointed by the patient as his or her durable power of attorney and/or durable power of attorney for health care and the patient has an impairment that prevents him/her from making decisions on his/her own behalf.

Staff Signature _____ Date Released_____

**Return to your child's building