MEDICAL DENTAL OPTOMETRY
ENROLLMENT FORM

Thank you for choosing HEALS, Inc. as the healthcare provider for your child.

Health Establishments At Local Schools
Part of the Solution

Please complete all sections of this form in full.
Incomplete forms may delay or prevent enrollment.

Demographics

Patient's Name: _____
First *Middle* *Last*

Gender: ☐ M ☐ F Gender Identity: _____ Date of Birth: _____ SSN: _____

Race/Ethnicity (optional): ☐ African American ☐Caucasian ☐Hispanic ☐ Native American ☐ Asian

Address: _____ City: _____State: _____Zip Code: _____

Home phone: _____ Attending School: _____

Parent/Legal Guardian's Name(s)_____Date of Birth: _____

Cell Phone: _____Work Phone: _____

Email_____ Another phone we may contact: _____

How did you hear about us? _____

Siblings Name (if any)	Date of Birth	Enrolled at HEALS?	Does this child have Medicaid?
_____	_____	☐Yes ☐No	☐Yes ☐No
_____	_____	☐Yes ☐No	☐Yes ☐No
_____	_____	☐Yes ☐No	☐Yes ☐No

Responsible Party

Name of the responsible party (Parent/Guardian): _____

Social Security #: _____ DOB: _____ Gender: ☐Male ☐Female

Employment Status: ☐ Employed. ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Student

Employer's Name: _____ Hire Date: __/___/_____ Telephone: _____

Address: _____ Job Position: _____

My child is uninsured: ☐Yes ☐No

My child has Medicaid ☐Yes ☐No If YES, please provide Medicaid number: _____

My child has other insurance: _____
(Company Name, i.e., BCBS, All Kids, United)

Insurance Number: _____ Group Number: _____

Insured Person's Name: _____ Relationship to the child: _____

Insured's date of Birth: _____ Is Dental Care Included: ☐ Yes ☐No

Write your initials in the box for every service you want your child to receive. Boxes left blank mean you do *not* give consent for that service.

Medical Services	Dental Services	Optometry Services	Description
____	____	____	**By initialing I consent** to my child may receive services at any HEALS Clinic **WITHOUT** me being present. I authorize HEALS staff to perform screenings and provide patient education. Medications may be administered if necessary. I will be informed of visits via note or phone call. If you initial this option, PLEASE COMPLETE THE ENTIRE FORM.
____	____	____	**By initialing I consent** to my child may receive services at any HEALS Clinic ONLY with me being present. I authorize HEALS staff to perform screenings and provide patient education. Medications may be administered if necessary. PLEASE COMPLETE THE ENTIRE FORM.

Patient Name: _____ DOB: _____

How would you like to be contacted regarding appointments, treatment, and/or other information concerning your child's healthcare at HEALS? Please check all that apply.

☐Home Phone ☐Work Phone ☐Cell Phone ☐Note sent home ☐Patient Portal ☐Text ☐Email.

Voicemails opt-out: If you prefer that **we do not leave a voicemail** at the number(s) you have given us. **Initial here:** _____

I understand that all the information on my child's health record is confidential. I consent to the HEALS clinic staff to speak with appropriate school personnel concerning my child's school and health records, attendance, academic performance, and other information affecting his/her learning and/or behavior.
_____ **Initial here that you understand**.

I authorize the HEALS clinics to release information regarding treatment to doctors, dentists, and third-party payers (insurance companies) for the purpose of obtaining authorization for services, for billing, and for any reason in accordance with acceptable medical practice pursuant to the law. I authorize payments to be made directly to the provider of services.
_____ **Initial here that you understand**.

I understand that it is my/our (parent/guardians') responsibility to provide HEALS with copies and proof of all updated court documents regarding custody.
_____ **Initial here that you understand**.

Audio and video recordings are not allowed. Such recordings interfere with medical and dental treatments and the privacy of our staff and patients.
_____ **Initial here that you understand**.

HEALS No-Show Policy: I understand that if I miss two (2) appointments without notice, my account will be placed on probation. If I miss three (3) appointments, my child may be dismissed from HEALS practice.
_____ **Initial here that you understand**.

HEALS No-Show for Multiple Children Policy: I understand that if I fail to bring my multiple children for their same-day appointment, I will not be able to schedule their next appointments to occur on the same day. The above no-show policy also applies. Only two kids per day may be scheduled at a time.
_____ Initial here that you understand.

HEALS Late Arrival Policy: If I arrive 10 minutes or later for my scheduled appointment, HEALS has the right to reschedule my child's appointment.
_____ **Initial here that you understand**.

HEALS Cancellation Policy: I understand that **all cancellations must be made at least 24 hours before the scheduled appointment**. If I cancel with less than 24 hours' notice, it will count as **half (½) of a no-show**. If I reach **three (3) no-shows**, my child **may be dismissed** from the HEALS practice.
_____ Initial here that you understand.

Name of the parent or guardian filling this Enrollment Form: _____
SIGN HERE: _____
Relationship to child: _____ Date: _____

HEALS Patient Portal

Get secure and easy access to your medical records and the HEALS professional staff.

Through the Patient Portal, you can:

- View your lab results.
- Send messages to the HEALS staff
- View your medical information such as medication lists, problem lists, allergies, and immunization records.
- Receive appointment reminders and confirm appointments.

Important: The Patient Portal is **not for emergencies**.

- If you have a medical emergency, **call 911** or **go to the nearest emergency room** right away.
- Messages sent through the portal are only read during normal clinic hours.

To Get Started: Ask for your login information on your next office visit.

MEDICAL HISTORY

Please complete all sections of this form in full.

Patient's Name: _____
First *Middle Initial* *Last*

Date of Birth: _____(*MM/DD/YYYY)*

Primary Care Doctor or Nurse Practitioner (assigned by insurance or the doctor your child sees when sick):

Name of the child's Physician: _____ Phone: _____

Name of child's Dentist: _____ Phone: _____

Name of the Eye Doctor: _____ Phone: _____

Does your child have allergies (bee stings, foods, medicines, etc.)? ☐Yes ☐No

If yes, please list:

Allergy	1st Onset	Reaction (Itching, Swelling, Hives, Anaphylactic, etc.)

Is your child taking any daily medications? ☐Yes ☐No

If yes, please list:

Name	Dosage	Route Taken (Orally, Injected, Etc.)	Frequency

Is your child allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex

☐Sulfa Drugs ☐ Other, please explain_____

Is your child currently being treated for any condition (s) or illness (es)? ☐Yes ☐No

Which illness: _____When did it start: _____

Was your child born prematurely? ☐Yes ☐No

If yes, please explain: _____

Has your child ever been in the hospital overnight or longer: ☐Yes ☐No

Please explain when and why: _____

Has your child ever had surgery? ☐Yes ☐No

Please explain: _____

Has your child ever been given a general OR local anesthetic? ☐Yes ☐No

Please explain: _____

Has a physician or dentist ever suggested that the patient take **antibiotics** before seeing the dentist? ☐Yes ☐No

Please explain why and provide the name of the doctor making that recommendation:

Why: _____

Doctor's name: _____Phone: _____

Does your child have any genetic (inherited) conditions? ☐Yes ☐No

Please explain: _____

Do you have any concerns about your child's physical health? ☐Yes ☐No

Please explain: _____

Patient Name: _____ DOB: _____

Has your child ever had any of the following illnesses or conditions?

Disease or Disorder	Yes	Disease or Disorder	Yes	Disease or Disorder	Yes
ADHD	☐	Easily Winded	☐	Liver Disease	☐
AIDS/HIV	☐	Emphysema	☐	Low Blood Pressure	☐
Anaphylaxis	☐	Emotional Problems	☐	Lung Disease	☐
Anemia	☐	Epilepsy/Seizures	☐	Jaw Pain	☐
Angina	☐	Excessive Bleeding	☐	Parathyroid Disease	☐
Anxiety	☐	Excessive Thirst	☐	Psychiatric Care	☐
Arthritis	☐	Fainting Spells	☐	Radiation Treatments	☐
Artificial Heart Valve	☐	Frequent Cough	☐	Recent Weight Loss	☐
Artificial Joint	☐	Frequent Ear Infections	☐	Renal Dialysis	☐
Asthma	☐	Frequent Eye Infections	☐	Rheumatic Fever	☐
Autism	☐	Frequent Headaches	☐	Rheumatism	☐
Bladder Problems	☐	Genital Herpes	☐	Scarlet Fever	☐
Blood Disease	☐	Glaucoma	☐	Sickle Cell Disease	☐
Blood Transfusion	☐	Growth Problems	☐	Sinusitis	☐
Breathing Problems	☐	Hay Fever	☐	Spina Bifida	☐
Bruise Easily	☐	Hearing Problems	☐	Stomach/Intestinal Disease	☐
Cancer	☐	Heart Attack	☐	Stroke	☐
Cerebral Palsy	☐	Heart Conditions	☐	Swelling of Limb	☐
Chemotherapy	☐	Hemophilia	☐	Thyroid Disease	☐
Chest Pains	☐	Hepatitis A, B, or C	☐	Tonsillitis	☐
Cold Sores	☐	Herpes/Shingles	☐	Tuberculosis	☐
Congenital Heart Disorder	☐	High Blood Pressure	☐	Tumors or Growths	☐
Convulsions	☐	High Cholesterol	☐	Ulcers	☐
Cortisone Medication	☐	Hives or Rash	☐	Venereal Diseases	☐
Developmental Issues	☐	Hypoglycemia	☐	Yellow Jaundice	☐
Depression	☐	Irregular Heartbeat	☐	Other (please specify):	
Diabetes	☐	Kidney Problems	☐	_____	
Drug Addiction	☐	Leukemia	☐	_____	

Check here if none of the above ☐

Please provide the dates of Diagnosis and Explanations if you answer "YES" to any of the conditions above.

_____

Has your child had any serious illnesses that are not listed above? ☐Yes ☐No

Please explain: _____

Do you have any concerns about your child's emotional health? ☐Yes ☐No

Please explain: _____

How would you describe your child's eating habits? _____

How often does your child drink: Sodas: ___/week Juices: ___/ week Energy Drinks: ___/week

How often does your child eat: Candies: ___/week Fruits: ___/week Vegetables: ___/week Meats: ___/week

Is your child up to date with immunizations related to patient hood diseases (tetanus, measles, mumps, etc.)?

☐ Yes ☐ No

If of the appropriate age, what is the patient's Human Papillomavirus/HPV immunization status?

☐ Immunized ☐ Not Immunized

SIGN HERE: _____ Relationship to child: _____ Date: _____

Patient Name: _____ DOB: _____

HEALS LIABILITY WAIVER

HEALS, INC. AND THE MEDICAL PROFESSIONALS IN THIS FACILITY ARE NOT LIABLE FOR DAMAGES RESULTING FROM THE PROVISION OF MEDICAL OR DENTAL CARE, EXCEPT IN THE CASE OF MISCONDUCT.

HEALS, Inc. provides medical treatment, dental treatment, optometry treatment, diagnosis, advice, or nursing services as a part of the services of an established free medical clinic. As a free medical clinic, HEALS, Inc. and the medical and dental professionals who provide care at this facility shall not be liable for civil damages as a result of his or her acts or omissions in providing medical treatment, dental treatment, optometry treatment, diagnosis, advice, or nursing services, unless the act or omission was the result of the licensed healthcare provider's willful or wanton misconduct.

The immunity from civil liability also applies to medical professionals who provide, without fee or compensation, further medical treatment, diagnosis, advice, or nursing services to a patient upon referral from this facility.

Acceptance by this facility of a contribution made by a person receiving services at this facility will not constitute a waiver of immunity.

In any suit against HEALS, Inc. for civil damages based upon the negligent act or omission of a volunteer medical professional, proof of such act or omission shall not be sufficient to establish the responsibility of HEALS, Inc. under the doctrine of "respondeat superior," notwithstanding the immunity granted to the volunteer medical professional with respect to any act or omission included under Ala. Code (1975) §6-5-663(a), unless such act or omission is found to be willful or wanton.

Ala. Code (1975) §6-5-663.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I acknowledge that a copy of the HEALS, Inc. Notice of Privacy Practices has been made available to me. Regarding the Notice, I also acknowledge that I have been given the opportunity to ask questions about the Notice and its content. I understand that the most up-to-date version of the Notice will be posted, and copies will be available at any time. The full text detailing our privacy practices is available for your review. We encourage you to read it and ask any questions you may have about our privacy practices.

☐ **I have read and understand the *Notice of Privacy Practices*.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Relationship to Child: _____ Date: _____

Signature: _____ Date: _____

This section is designated only if the patient is over 16 years old.

Patient Name: _____ DOB: _____

HEALS IMMUNIZATION SCHEDULE

It is the policy of all HEALS physicians that your child/children receive all immunizations required by the American Academy of Pediatrics. This is a non-negotiable policy for all HEALS physicians. It is our policy that all HEALS patients keep all scheduled well-child checkup appointments yearly until they are eighteen years old.

Newborn	Newborn Screen	12 Months	MMR, Varicella, Pneumococcal Hepatitis A*
2 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	15 Months	DTaP, HIB
4 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	18 Months	Hepatitis A*
6 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	4-Year	DTaP, MMR, Varicella, IPV
9 Months	PPD	11-Years & up	HPV*, Tdap, Meningococcal*

The following immunizations are not *required* but are recommended by the physicians at HEALS Pediatrics:

*Rotavirus
*Hepatitis A
*Meningococcal
*HPV

If you miss three consecutively scheduled well-child checkup appointments, refuse to comply with the required immunizations or excessively abuse scheduled appointments; your child/children will be considered for dismissal from HEALS.

I acknowledge receipt of the immunization policy of HEALS Pediatrics, and by registering my child as a patient of HEALS, I agree to comply with the required immunizations.

_____ With my initials I acknowledge that I have read and understand the *HEALS IMMUNIZATION SCHEDULE*.

Permission to Share Health Information

This section is to be completed by patients age 16 and older

Any physician, staff, employee, or representative of HEALS, Inc. has my permission to discuss and / or disclose my information regarding medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information to facilitate and coordinate my care and treatment with the following persons:

Contact Name: _____ Relationship to the patient: _____
Phone number: _____ Expiration Date: _____

Contact Name: _____ Relationship to the patient: _____
Phone number: _____ Expiration Date: _____

Consent to call: ☐YES ☐ NO Consent to text: ☐ YES ☐ NO

Name of the Parent/Guardian: _____

Signature: _____ Date: _____
Patient or Legally Authorized Representative

Relationship to the Patient: _____ Phone Number: _____

HEALS, Inc.
Health Establishments
at Local Schools

515 Sparkman Dr. NW
Huntsville, AL. 35816

Phone: 256-428-7560
Fax: 256-428-7561

Health Establishments At Local Schools
Part of the Solution

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY RELEASE A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORDS

Full Name of Patient: _____

Patient's Birth Date: _____ Chart# _____

Please provide the information about the Medical Office or Physician to whom we must request the records:

Physician's name/Practice name: _____

Phone number/Fax: _____

Address: _____

INFORMATION TO BE RELEASED (X) ☐ Medical Record ☐ Psychiatric Records

**If only a portion of the medical record or Psychiatric record is required, please specify. **

☐ Discharge Summary	☐ Emergency Room	☐ Laboratory Results
☐ History & Physical	☐ X-Ray Report	☐ Immunization Records
☐ Orders	☐ Operative Reports	☐ Nurses' Notes
☐ Radiology Film/Imaging	☐ Progress Notes	☐ Entire Record

☐Other (Specify) _____

Information is requested by: _____, Clinic Coordinator at the HEALS Clinic. This record is requested to be released to:

HEALS, Inc.
_____
Phone: 256-428-7560
Fax: 256-428-7561

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

☐ Continued Medical Care ☐Insurance purposes ☐Other

The authorization must be signed and dated and may be revoked by notifying HEALS, Inc. in writing at any time except to the extent that action has been taken prior to revocation. This consent will expire 120 days after the date below or sooner by my choice., in which case this consent will expire on this date or event: _____

Name of the Parent/Guardian: _____

Signature: _____ Date: _____

Parent or Legally Authorized Representative

Relationship to the Patient: _____ Phone Number: _____

Sliding Fee Scale Application

Providing proof of income is optional. However, without it, we cannot apply for any discounts, and you will be responsible for the full cost of services. This information is used ONLY at HEALS Clinics, and we will not share your personal information.

Patient's Name:		Date of Birth:		Date:
Social Security Number:		Age:	Male	Female
Is the patient a Full-Time Student? ☐Yes ☐No	School Name:		Grade	Teacher
Household Income #1 Name:			Household Income #1 Social Security #:	
Home #:	Work #:		Cell #:	
Current Address:	Street	City	State	Zip
County:		How long have you been living here?		
Parent/Guardian Employer:		Hire Date: (month/day/year)		
If unemployed – last date worked (month/day/year)		Reason:		
Household Income #2 Name:		Parent/Guardian #2's Social Security #:		
Home #:	Work #:		Cell #:	
Current Address:	Street	City	State	Zip
County:		How long have you been living here?		
Employer:		Hire Date: (month/day/year)		
If unemployed – last date worked (month/day/year)		Reason:		
Are you Renting? ☐Yes ☐ No	Buying ☐Yes ☐ No	Do you Own ☐Yes ☐ No	Living with and/or supported by someone? ☐Yes ☐ No	Who?
Number of people living in household:		Relation to you?		
List the ages of **YOUR** children still living in the household:				
Have you ever applied for SSI/Social Security Disability?		Date of last application:		

Information to Connect You with Resources

Please check all that apply:

Homeless: ☐Yes ☐No **Public Housing** ☐Yes ☐No

Worker Status: ☐Migrant ☐Seasonal ☐Not Migrant/Seasonal ☐Refuse to answer.

Disabled: ☐Yes ☐No **Military Discharge:** ☐Yes, **Discharge Date**_____☐No

Refugee Status ☐Yes ☐No **Country of Origin:** _____

Patient's Name _____ DOB: _____

MONTHLY INCOME & MONTHLY EXPENSES

This information is for HEALS Clinics ONLY Eligibility is determined based on family size and income compared to Federal Poverty Guidelines. Patients will not be denied services based on an inability to pay.

Income Type	Amount	Expenses/Bills Type	Amount
Monthly Gross wages/unemployment -Income #1		Rent, house, or trailer payment	
Net wages after taxes - Income #1		Land/lot payment	
Gross wages - Income #2		Utilities / Gas / Water	
Net wages after taxes - Income #2		Food / Phone Bill	
Gross wages/salary - Additional Income		Car payment / Car Insurance	
Net wages after taxes - Additional Income		Car payment / Car Insurance	
		Child support/alimony payment	
Social Security check amount #1		Daycare/childcare expense	
Social Security check amount #2		Education/college loans	
Social Security check amount (child)		List of all insurance premiums paid:	
SSI Income (list amount & recipient)		Hospital/daily indemnity	
Military/Reserves Income		House/renters insurance	
Short/long term disability income		Health/ Medical insurance	
Unemployment check amount		Student insurance	
Retirement/pension check amount		Life/burial insurance	
Rental income receives		Cancer insurance	
AFDC/Family Assistance		Doctor and medical expenses (monthly)	
Church assistance received		Prescription costs (out of pocket)	
Other income or money received		Other expenses:	
TOTAL MONTHLY HOUSEHOLD INCOME:	$	**TOTAL MONTHLY HOUSEHOLD EXPENSES:**	$

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that HEALS Inc. has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving HEALS, Inc.; permission to access my credit file and to provide my financial information to those companies contracted by HEALS, Inc. for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with regarding completing the financial application process, please list them below as a designated person in the space provided.

_____ _____

Printed Parent/Guardian's Name Parent/Guardian's Signature

Witness Signature _____ Date: _____

REQUIRED DOCUMENTS

To apply for the Sliding Fee Discount Program, please provide **current proof of income**. Documentation must reflect your **most recent earnings** and may include one or more of the following:

- Most recent **income tax return** or **W-2 form**
- **Two most recent pay stubs**
- **Most recent unemployment check or benefits statement**
- Proof of **other household income** (such as Social Security, pension, disability, or child support)
- **Bank statements** showing direct deposits
- **Self-Declaration of Income Form**, only if no other proof of income is available.

If proof of *gross (before-tax)* income is not available, income may be **estimated based on net income** documentation.