School-Based Pediatric Registration Form

Revised 8/12/2026

PHC PARTNERSHIP HEALTH CENTER

MINOR'S PERSONAL INFORMATION			
Minor's First Name	**MI**	**Minor's Last Name**	**Minor's Preferred or Chosen Name**

Minor's Date of Birth (MM/DD/YYYY)	**Minor's Social Security Number**	**Minor's Legal Sex**
		[ ] Male [ ] Female [ ] Nonbinary

CONTACT AND ADDRESS INFORMATION		
Minor's Cell Phone	**Minor's Primary Home Phone**	**Minor's Email Address** *(please print clearly)*

What is the preferred contact method for the minor?	[ ] Cell Phone [ ] Home Phone [ ] MyChart
How would you like to receive bills from PHC?	[ ] Paperless (Text/Email) [ ] Mail

Minor's Primary Language	**Does the minor need an interpreter?**	**Hard of Hearing**
[ ] English [ ] Other: _____	[ ] Yes [ ] No [ ] ASL	[ ] Yes [ ] No

Minor's Primary Mailing Address	**City**	**State**	**ZIP**
Minor's Physical Address ***(if different from mailing address)***	**City**	**State**	**ZIP**

Does the minor live in a group home or congregate care home?	[ ] Yes [ ] No [ ] Choose Not to Answer
Is the minor experiencing houselessness?	[ ] Yes [ ] No [ ] Choose Not to Answer
If not, is there concern about losing housing?	[ ] Yes [ ] No [ ] Choose Not to Answer
If the minor is currently houseless, where do they sleep at night?	[ ] On the Street or in a Car [ ] Doubling Up (Staying with a friend or Family Member) [ ] Shelter [ ] Transitional Housing [ ] Permanent Supportive Housing [ ] Other: _____

ADDITIONAL INFORMATION

Our life experiences play an important role in our health and well-being. We ask you these questions so we can better understand your experience and give you the best possible care. Please answer what you feel comfortable answering. Thank you!

Minor's Marital Status:	[ ] Single	[ ] Married	[ ] Significant Other	[ ] Divorced
	[ ] Legally Separated	[ ] Widowed	[ ] Choose not to disclose	
Minor's Employment Status:	[ ] Full-time	[ ] Part-time	[ ] Retired	[ ] Migrant
	[ ] Unemployed	[ ] Seasonal	[ ] Other: _____	
	[ ] Student	[ ] Seasonal Agricultural Worker		
Is the minor employed in healthcare?	[ ] Yes	[ ] No	**What is the minor's religion?**	

Minor's Sex Assigned at Birth	**Minor's Pronouns**
[ ] Female [ ] Male [ ] Intersex	[ ] She/Her/Hers [ ] They/Them/Theirs
Minor's Gender Identity	[ ] He/Him/His [ ] Not Listed: _____
[ ] Female [ ]Male	**Minor's Sexual Orientation**
[ ] Nonbinary [ ] Genderqueer	[ ] Straight [ ] Lesbian or Gay [ ] Bisexual
[ ] Two-spirit [ ] Choose not to answer	[ ] Don't Know [ ] Asexual [ ] Choose not to answer
[ ] Identity not Listed: _____	[ ] Orientation not listed: _____

Minor's Race ***(check all that apply)***			
[ ] American Indian or Alaskan Native	Tribal Affiliation: _____		
[ ] Black or African American	[ ] White	[ ] Asian Indian	[ ] Korean	[ ] Chinese
[ ] Japanese	[ ] Vietnamese	[ ] Thai	[ ] Filipino	[ ] Other Asian
[ ] Native Hawaiian	[ ] Chamorro	[ ] Guamanian	[ ] Samoan	[ ] Tongan
[ ] Other Pacific Islander		[ ] Race not listed	[ ] Choose not to answer	

School-Based Pediatric Registration Form

Revised 8/12/2026

PHC PARTNERSHIP HEALTH CENTER

Minor's Ethnicity				
[ ] Hispanic, Latino or Spanish Origin	[ ] Not of Hispanic, Latino, or Spanish Origin	[ ] Mexican, Mexican American		
[ ] Cuban	[ ] Puerto Rican	[ ] Ethnicity not listed	[ ] Choose not to answer	
Minor's Veteran Status	[ ] Yes -Separated	[ ] Yes -Currently Serving	[ ] No -Never Served	[ ] Choose not to answer
Minor's Insurance	***A copy of the front and back of the minor's insurance cards are <u>REQUIRED</u>.***			
Name of Insurance: _____	Type of Insurance: [ ] Medical [ ] Dental			
Subscriber Number:	Subscriber's Name:			
Group Number:	Subscriber's Employment Status:	Subscriber's DOB:		

PARENT OR LEGAL GUARDIAN – Please list all parent or legal guardian information below

We Require Legal Documentation of Legal Guardians

First Name	**MI**	**Last Name**	**Date of Birth**

Social Security Number	**Relationship to Patient?** *(e.g. parent, grandparent, legal guardian, power of attorney)*

Mailing Address (*If different from patient)*	**City**	**State**	**ZIP**

Phone Number	**Employment Status**	**Email Address** *(please print clearly)*

Language	**Notify on Admission to Hospital**	**Authorized Mail Receiver**
	[ ] Yes [ ] No	[ ] Yes [ ] No

ADDITIONAL PARENT OR LEGAL GUARDIAN – Skip this section if there is no additional parent or legal guardian

We Require Legal Documentation of Legal Guardians

First Name	**MI**	**Last Name**	**Date of Birth**

Social Security Number	**Relationship to Patient?** *(e.g. parent, grandparent, legal guardian, power of attorney)*

Mailing Address (*If different from patient)*	**City**	**State**	**ZIP**

Phone Number	**Employment Status**	**Email Address** *(please print clearly)*

Language	**Notify on Admission to Hospital**	**Authorized Mail Receiver**
	[ ] Yes [ ] No	[ ] Yes [ ] No

EMERGENCY CONTACTS – For emergency use only. Listing individuals below does not authorize them to schedule appointments or discuss your protected health information with us. If you would like any of the individuals listed below to assist with scheduling appointments or have access to your protected health information, please speak with our front desk staff.

Full name	**Relationship**	**Phone Number**	**Same Household**	**Notify on Admission**
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No

School-Based Pediatric Registration Form

Revised 8/12/2026

PHC PARTNERSHIP HEALTH CENTER

HOUSEHOLD INCOME INFORMATION

To maintain federal funding for our discounted services, we are required to collect household and income information from all our patients, including those who choose not to apply for financial support. Even if you do not plan to apply for assistance, please help us continue to offer discounts by answering the questions below. Thank you!

WHAT IS A HOUSEHOLD?

A household includes all individuals who live together and are related by birth, marriage, or adoption. It also includes all individuals who may or may not live together but share a taxed household.

Including yourself, how many people live in your household?	
What is your estimated yearly household income?	**$**

A separate application is required to apply for the Sliding Fee Scale. Are you interested in applying for the Sliding Fee Scale?

*[ ] **YES**- I have received information on PHC's sliding fee scale. I would like to apply for this discount. I will provide proof of income for every working member of my household.*	*[ ] **NO**- I have received information on PHC's sliding fee scale, and I choose not to apply for this discount. I understand that if I am experiencing houselessness or have Medicaid, a slide may be set for my benefit. I understand that after my insurance payments, I will be billed at full fee for balances not covered by my insurance.*

Ask for MyChart activation code to sign up!

MyChart
Your secure online health connection

Consent for Health Care Services, Payment, and Information Sharing

Your Consent to Receive Health Care Services

I request and consent to health care services for myself and/or my dependent(s) from Partnership Health Center (PHC). I understand that PHC functions as a Patient-Centered Medical Home, meaning care is provided in a team-based setting focused on coordination, continuity, and quality of care.

I understand that care may be provided by a care team that includes licensed clinicians, pharmacists, residents, students, and other health professionals, as allowed by law and organizational policy. Some services may be provided under a Collaborative Practice Agreement (CPA). A CPA allows physician assistants and/or pharmacists to provide specific patient care functions under appropriate collaboration with my primary care provider.

I understand that I have the right to ask questions, request clarification, and participate in decisions about my care. I agree to provide accurate and complete information to support safe and effective treatment.

Payment, Insurance, and Financial Responsibility

I understand that Partnership Health Center is a Federally Qualified Health Center and provides access to services regardless of ability to pay. Fees are based on PHC's standard charges, as well as patient eligibility for the sliding fee discount program.

I understand that while, as a courtesy to me, PHC will bill appropriate governmental or private insurance plans, I am ultimately responsible for all of PHC's charges, including charges not covered by insurance or discount eligibility. I authorize PHC to bill and release my information to my insurance or other third-party payor for medical, dental, behavioral health, and pharmacy services and to receive payment directly when permitted.

I agree to notify PHC of any changes to my insurance status, income, or household size that may affect eligibility or charges.

Notice of Privacy Practices and Patient Rights

I acknowledge that I have received or had the opportunity to review PHC's Notice of Privacy Practices and Patient Rights and Responsibilities, and that I may obtain a copy of such Notice upon request. This Notice explains how my health information may be used and disclosed, my rights regarding that information, and how I may access my medical records, among other rights and responsibilities.

Use and Sharing of Health Information

I understand that PHC is required by law to report certain health conditions, including communicable diseases and other events that require mandatory disclosure, to public health authorities.

I understand that my health information may be accessed or reviewed by authorized external entities for quality improvement, audits, program oversight, accreditation, and compliance with federal or state healthcare requirements. For more

information, please see the Notice of Privacy Practices.
Partnership Health Center participates in Health Information Exchanges (HIE). This means your health information-including medical history, medications, test results, allergies, and diagnoses- can be securely and electronically shared with other authorized healthcare providers such as hospitals, clinics, specialists, and other authorized uses. Only healthcare providers and other entities with approved, controlled access can view your records.
Sharing your information through HIE helps your care team provide better, more coordinated care- especially if you are traveling, needing emergency treatment, or are seeing a provider outside our organization. It also makes it easier for providers to access important medical information when they need it and reduce unnecessary duplicate tests.
Please see our Notice of Privacy Practices for more information. Certain HIEs host opt-out options, permitting you to opt out of having your information accessible in HIE. If you have questions or would like information on how to opt-out of these HIEs, we can help direct you to each HIE's opt-out process. It is your responsibility to opt-out directly with HIE should you choose to do so.
If you opt out, your information will continue to be shared with HIE, but other providers will not be able to see your records through HIE, which may limit their access to your complete medical history emergencies.

Use of Technology and Artificial Intelligence (AI) in Care
PHC uses secure technology tools, including electronic health records and clinical support systems, to assist in providing care. Some tools may include automated or artificial intelligence-supported functions used to support documentation and clinical review.
These tools may help document visits, organize medical information, review records, suggest evidence-based care options, and reduce paperwork, so providers can focus more on patient care. AI tools do not replace your provider. Your provider remains fully responsible for medical decisions and your care plan. AI systems used by the clinic follow federal privacy laws, including HIPAA.
You may ask questions about how AI is used. You may request that certain AI tools not be used during your visit when reasonably possible, and we will accommodate such requests to the extent we are reasonable able to do so. Declining AI use will not affect your access to care.

Nondiscrimination Statement
PHC complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other protected status. PHC provides free aids and services to people with disabilities and language assistance services to individuals with limited English proficiency.
If you believe PHC has failed to provide these services or discriminated in another way, you may file a grievance with PHC or the U.S. Department of Health and Human Services, Office for Civil Rights.

Acknowledgment and Signature
By signing below, I acknowledge that I have read or had explained the information above to me and have had the opportunity to ask questions.

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____

Relationship to the Patient: _____ Date: _____