

San Diego Unified School District/La Maestra Mobile Clinic

Parent/Legal Guardian Consent Form

Student Name: _____ Grade: _____

Address: _____ Zip: _____

Birthdate: _____ Social Security # _____

Race: _____ Sex: _____

Parent/Guardian: _____ Daytime Phone: _____

In an emergency call: _____ Relationship: _____ Phone: _____

Serious Illnesses: _____ Medications taken regularly: _____

I have read and understand the services offered at La Maestra Mobile Clinic as described below. I further understand that the services authorized by my signature on this form are simple, common or routine health care services and treatment will be limited to:

Diagnosis and treatment of minor and acute illness, first aid for minor injuries, physical examinations, general assistance with chronic (ongoing) illness such as asthma, seizure disorder, diabetes, acne, immunizations, vision and hearing screening, psychological services (including mental health services), prescription and over the counter medicine, diet and weight control programs/nutrition counseling, family planning information and referrals, referrals for health care services which cannot be provided at the La Maestra Mobile Clinic such as laboratory and x-ray services.

I have listed below the services which I **DO NOT** want this student to receive at the La Maestra Mobile Clinic.

I understand that this consent covers only those services provided at the clinic, and does not authorize services rendered at any other private or public facility.

I hereby authorize a physician and other professional staff to provide necessary and/or advisable treatment for my son/daughter. This student has my permission to receive all services offered at the La Maestra Mobile Clinic **EXCEPT** those which I have specifically excluded above.

We understand that students are registered Directly with La Maestra Family Clinic when receiving care at the Mobile Clinic and this will make it easier if we choose to go to the La Maestra Family Clinic for additional services not available at the Mobile Clinic, such as dental care and immunizations.

Medical records will be kept confidential manner, however, I acknowledge that the La Maesrta Mobile Health Clinic may release information regarding treatment to third party payers such as Medi-Cal or insurance companies for the purpose of billing and for any reason in accordance with acceptable medical practice pursuant to law.

Signature of Parent/Legal Guardian: _____ **Date:** _____

Student's Signature: _____ **Date:** _____

If your child has health insurance or another physician please complete the following:

Insurance/Provider Name: _____ Phone #: _____

"The San Diego Unified School District does not discriminate with regard to sex, race, religion, color, national origin, ancestry/ethnicity, martial status, age, physical or mental disability, sexual orientation or any other unlawful consideration."



LA MAESTRA
COMMUNITY HEALTH CENTERS
 City Heights · El Cajon · National City · Lemon Grove

- La Maestra City Heights La Maestra National City La Maestra El Cajon 1032 Broadway La Maestra El Cajon La Maestra HOPE Clinic La Maestra Hoover High School La Maestra Rosa Parks La Maestra Monroe Clark La Maestra Central Elementary

PATIENT I.D. CARD	
PATIENT NAME _____	
MR# _____	DOB _____ M _____ F _____
PRIMARY PROVIDER _____ DATE _____	

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: Last _____ First _____ MI _____ Other Name(s) used _____
 Social Security Number _____ - _____ - _____ Date of Birth ____/____/____ Male Female
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 What is the patient's primary language? _____
 May we contact you by phone? Yes No If yes, may we leave a brief or extend message on your phone?
 May we contact you by text message? Yes No If yes, data rates may apply. La Maestra is not responsible for data charges.
 Please check here if you understand and agree that you are responsible for text and phone charges: Yes No
 May we contact you by email Yes No Email address: _____
 Marital Status: Single Married Divorced Separated Widowed Partner
 Student: Yes No If yes, Full-time Part-time
 Phone (home) _____ (work): _____ Cell: _____

INSURANCE INFORMATION			
Primary Insurance Company Name	Insured Member Name	DOB	Insurance ID#
Medi-Cal ID#	Medicare ID#		
Secondary Insurance Company Name	Insured Member Name	Insurance ID #	Insured Employer

If Uninsured or underinsured, are you interested in eligibility assistance for health coverage? Yes No

Employed: Yes No If yes, Full-time Part-time
 Employer: _____ Address: _____
 Preferred Pharmacy: _____ Address: _____ Phone Number: _____

RESPONSIBLE PARTY (if patient is a minor complete this section)

Name: Last _____ First _____ MI: _____
 Relationships to patient: _____ Phone (home): _____ (work): _____
 Address (if different): _____ City: _____ State _____ Zip: _____
 Date of Birth ____/____/____ Social Security Number: _____ - _____ - _____ Employer: _____

EMERGENCY CONTACT

Name: _____ Phone Number (home): _____
 Relationship to patient: _____ Phone Number (work): _____

ADDITIONAL PATIENT INFORMATION (please answer all questions)

La Maestra is a nonprofit organization committed to serving the needs of our community. By answering the following questions, you will provide us with information we need to acquire grant funds to help uninsured and underserved individuals in our community. This information also helps us recognize clients who may qualify for specialty funded programs or services. Please help us by providing this information. This information will become part of your confidential medical record.

- a) Has patient been homeless at any time since January of this year? Yes No
 If yes, Homeless shelter Doubling up On Street In car or vehicle Unknown
 b) What type of work does the patient do? (Please check one): Homemaker Professional Clerical Sales Service Laborer Agriculture. If Agriculture: Employed year round Migrant Seasonal Unemployed Retired

- c) Preferred spoken language? English Spanish Arabic Other (please specify) _____
- d) Is a translator required? If yes, in which language? _____
- e) Does the patient reside in public housing? No Yes Does the patient receive section 8 housing assistance? No Yes
- f) Race (please check one): African American/Black American Indian/Native American Alaska Native Asian
 Caucasian/White Native Hawaiian Other Pacific Islander More than one Race Other (please specify) _____
- g) Ethnicity (please check one): Hispanic Non-Hispanic
- h) Are you a Veteran? Yes No
- i) Number of people in patient's household _____ Monthly household gross income (approximate): \$ _____
- g) Yearly household gross income (approximate): \$ _____

PAYMENT INFORMATION

La Maestra is a nonprofit organization. We depend on your prompt payment for services so that we can continue to provide high quality, low-cost care for our patients. We require payment at the time of service unless arrangements have been made with our billing department prior to the visit. We will bill your primary insurance carrier, but we do require you to pay your co-payment and any deductible you have not met at the time of service. We will bill supplemental insurance for our Medicare patients. Any amounts due after your insurance pays its portion will be billed to you. Payment is due upon receipt of your statement. You will be required to present your insurance card at each visit. _____(initials).

CONSENTS

In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent. Please provide us your consent by initialing each section below and by providing your signature below.

Assignment of Benefits/Financial Agreement: I authorize payment for all medical benefits to La Maestra for professional services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of payment default, I agree to pay all costs of collection, and legal fees. _____(initials).

Release of Information: I authorize the release of all information necessary to secure the payment of benefits related to my care. I further agree that a photo copy or signed digital in print of this agreement shall be as valid as the original. _____(initials).

CONSENT OF TREATMENT

I hereby authorize and consent to procedures necessary for diagnosis and treatment of myself and my family while a patient at La Maestra. _____(initials).

AUTHORIZATION TO REVIEW PHARMACY HISTORY

I hereby authorize La Maestra to view my prescription history from outside sources. _____(initials).

Your signature below indicates you have read, understand and agree to the above consents and to the patient rights and responsibilities.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

La Maestra is committed to protecting your personal health information in compliance with the law. The organization's Notice of Privacy Practices States the following:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose health information that we keep about you.
- Your rights as our patients relating to your personal health information
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

I hereby acknowledge that I have received/been offered a copy of La Maestra's Notice of Privacy Practices.

Signed: _____ Date: _____
 Parent/Patient's Representative: _____ Date: _____

 Description of Legal Authority to Act on Behalf of the Patient

Thank you for choosing La Maestra, and for your help in assuring that quality care is available in all communities served.



LA MAESTRA
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Notice of Advance Health Care Directive

(California Probate Code Section 4701 Acknowledgement of Receipt)

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the notice of Advance Directive of La Maestra Community Health Centers. This information is about your decision in advance of what medical treatments you want to receive in the event you become physically or mentally unable to communicate your wishes.

If you have any questions or need additional information about our notice of Advance Directive, please contact our administration office at **(619) 578-2584**.

I acknowledge receipt of the Notice of Advance Directive of La Maestra Community Health Centers.

Signature: _____ Date: _____
(*patient/parent/conservator/guardian*)

Inability to Obtain Acknowledgement

To be completed only if no signature is obtain. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was obtained.

Signature of provider representative: _____ Date: _____