Goodwin College Health Center Program

Offering: Medical and Behavioral Health Services

www.integratedhealthservices.org

PERMISSION FORM CONCERNING TREATMENT

Dear students, faculty, and staff members. Goodwin Health Center (GHC) is pleased to provide medical and mental health services at 403 Main Street. Please fill out the following form along with the HIPPA forms. Provide the secretary your Driver's License or State ID and also your Insurance Cards.

Patient Information: Please Print _____ **Student** _____ **Faculty/Staff**

Patient's Name:_____ Sex: Male____ Female____
Last First Middle

Address:_____ City:_____ Zip Code:_____

Birth Date:_____ Home Phone: _____ Cell Phone:_____

SSN:_____ Email:_____

Race (Circle): Asian American Indian/ Alaskan Native Black/African American/ Haitian Native Hawaiian/Pacific Islander White Other:_____

Ethnicity (Circle): Hispanic/Latino Non-Hispanic/ Non-Latino

Number of People Living in Household:_____ Combined yearly income:_____

Preferred Pharmacy:_____ Phone:_____

We will electronically submit all possible prescriptions

Emergency Contact Information

Name:_____ Relationship:_____ Cell phone:_____

Home Phone:_____ Work Phone:_____

Patient Insurance Information

1. Medicaid/Husky:_____ I do NOT have Insurance:_____
2. Private Insurance
   Insurance CO name:_____ Policy #:_____
   Group#:_____ Policy Holder Name:_____
   Policy holder DOB:_____ Policy Holder SSN:_____

Medical Care Information

Primary Care (MD/DO/PA/APRN):_____ Phone:_____
Clinic Name:_____ Fax:_____

A summary of the medical care provided here will be sent to your primary care clinic for their records.

Patient Name:_____ **DOB:**_____

Behavioral Health

Mental Health Provider: _____

Address: _____ Phone:_____

Do you want us to share details of this visit with this provider: Yes: _____ No: _____

Patient Medical History:

Current Medication: Please list all medications with name, dosages, and how often they are taken each day. Please include all over the counter medications taken daily

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication Allergies: _____

Other Allergies: _____

Surgeries: _____

Chronic Illness: _____

Hospitalizations: _____

Please place a √ by any of the following medical problems the Patient has

Yes/No

__ /__ Substance Abuse drugs or alcohol
__ /__ Mental Health treatment
__ /__ Anxiety/ Depression/ Bipolar
__ /__ Autism
__ /__ ADD/ ADHD
__ /__ Emotional Issues
__ / __ Headaches
__ / __ Blurred Vision
__ / __ Rashes
__ / __ Other Skin issues
__ / __ Changes in skin color
__ / __ Pelvic Disease
__ / __ Seizure disorder

__ /__ Migraine Headaches
__ /__ Vision Issues (Glasses or contacts)
__ /__ Hearing Impairment
__ /__ Frequent Sore Throat
__ / __ Difficulty Swallowing
__ / __ Reflux
__ /__ Stomach Aches
__ /__ Gallbladder disease
__ /__ Back Pain
__ / __ Joint Pain
__ / __ Broken Bones
__ / __ Menstrual Problems
__ / __ Stroke

__ /__ Diarrhea
__ /__ Constipation
__ / __ Blood in you Stool
__ / __ Unplanned Weight Loss
__ / __ High Blood Pressure
__ / __ Lightheaded
__ /__ Dizziness or Fainting
__ / __ Heart Murmur
__ / __ Diabetes
__ / __ Kidney stones
__ / __ Problems with Urination
__ / __ Thyroid Disease

__ / __ Asthma
__ /__ Problems Breathing
__ /__ Anemia
__ /__ Immune disease
__ / __ Mononucleosis
__ /__ Meningitis
__ / __ Swollen Glands
__ / __ Rheumatic Fever
__ / __ Vaginal Infections
__ /__ STD's
__ /__ UTI
__ / __ High Cholesterol

Female Patients Only: Age at first Menstrual cycle _____

How many pregnancies: _____

How many live births:_____

C- Sections: _____ Vaginal Deliveries: _____

Any Problems during your pregnancies: _____

Please provide a short explanation below if you answered yes to the above:

Family History:

Does anyone in your immediate family (i.e mother, father, brother, sister, grandmother, grandfather, aunt, or uncle) have any of the following conditions: Place a **√** next to the condition and provide family members relationship to you.

YES Relationship

___ Heart Disease: _____ ___ High Blood Pressure: _____ ___ Seizures: _____

___ Cancer: _____ ___ Mental Illness: _____ ___ Headaches: _____

___ Kidney Disease: _____ ___ Substance Abuse: _____ ___ Stroke: _____

___ Diabetes: _____ ___ Asthma: _____ ___ Arthritis: _____

___ Reproductive health problems: _____ ___ Respiratory disease: _____

Patient Name: _____ DOB: _____

Permission for Treatment and Payment

I hereby give my permission to Integrated Health Services INC (IHS) to provide assessment, diagnosis, and treatment. I hereby authorize IHS the ability to disclose any and all medical and or behavioral health treatment information for the purposes of treatment, payment or operational purposes.

Signature Date

I certify and attest that all of the above information is correct and true. I understand that IHS may verify this information, I also understand that the financial information provided will be used to determine eligibility for GHC sliding fee. I understand that if I intentionally misrepresent my income or family income that I will no longer be eligible to receive services at a discounted rate. I also understand that I am assuming all financial responsibility for all charges incurred and that payment is expected upon services rendered.

Signature Date