

JEFFERSON COMPREHENSIVE HEALTH CENTER, INC.

405 Main Street
P. O. Box 98
Fayette, MS 39069

TELEPHONE (601) 786-3475
FAX NO: (601) 786-9980

July, 2017

Dear Parent(s) and/or Guardian(s):

Jefferson Comprehensive Health Center (JCHC) provides primary health care services through School-Based health centers located within the Jefferson County School District and the Natchez-Adams County School District. JCHC will now be offering primary health care services at:

***Gilmer-McLaurin Elementary School
Morgantown Middle School***

***170 Sgt. Prentiss Drive, Natchez, MS 39120 &
101 Cottage Home Drive, Natchez, MS 39120***

The School-Based Health Center gives your child/children an opportunity to be treated by a licensed healthcare provider for any health care needs without being absent from school. You do not have to be present for your child to be treated, however, a consent form must be signed by you in order for any services to be rendered. Furthermore, due to the fact that you do not have to be present for your child to be treated, you will not have to take time off from work.

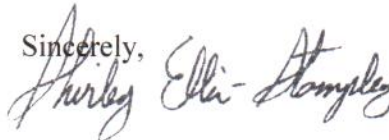
If you do not have insurance, there will be no cost for services. However, information will be made available for students who qualify for Medicaid/CHIP. If you do have insurance, it will be billed when your child is treated. The co-pay and deductible for students will be waived.

Please find attached the consent form and a HIPAA policy notification. Please return the completed consent form and HIPAA policy notification form to your child's teacher as soon as possible in order to receive healthcare services.

If you have any questions or concerns, please contact us at the numbers listed below:

<i>Jefferson Comprehensive Health Center, Inc. (Fayette)</i>	<i>601-786-3475</i>
<i>Gilmer Mc-Laurin Elementary School-Based Clinic</i>	<i>601-446-5646</i>
<i>Morgantown Middle School-Based Clinic</i>	<i>601-445-4806</i>

Thanks for allowing Jefferson Comprehensive Health Center to provide health care services for your child/children.

Sincerely,


Shirley Ellis-Stampley
Chief Executive Officer

JEFFERSON COMPREHENSIVE HEALTH CENTER PATIENT ANNUAL REGISTRATION FORM

PATIENT INFORMATION (Photo ID is required)				
NAME FIRST		MI	LAST	PATIENT ID#
STREET ADDRESS		CITY	STATE	ZIP COUNTY
HOME PHONE	SOCIAL SECURITY NUMBER		SEX/GENDER <input type="radio"/> FEMALE <input type="radio"/> MALE	DATE OF BIRTH
LANGUAGE <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> French <input type="radio"/> Arabic Would you like an interpreter? <input type="radio"/> No <input type="radio"/> Yes		EDUCATION - Highest Grade Completed <input type="radio"/> Elementary <input type="radio"/> High School <input type="radio"/> College <input type="radio"/> Post/Secondary /Graduate School		MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Partner
RACE and ETHNICITY (Check both 1 and 2): 1. <input type="radio"/> Black/African American <input type="radio"/> Asian <input type="radio"/> American Indian/Alaska native <input type="radio"/> White <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> More than 1 race			2. <input type="radio"/> Not Hispanic/Latino <input type="radio"/> Hispanic/Latino	AGRICULTURAL WORKER: <input type="radio"/> Seasonal <input type="radio"/> Migrant <input type="radio"/> Not Applicable
HOUSING: <input type="radio"/> Permanent resident <input type="radio"/> Shelter <input type="radio"/> Transitional <input type="radio"/> Doubling up <input type="radio"/> Street <input type="radio"/> Other <input type="radio"/> Public Housing (HUD, Section 8)		DISABLED <input type="radio"/> No <input type="radio"/> Yes, Date _____		VETERAN <input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> VISION IMPAIRMENT	EMERGENCY CONTACT: NAME		PHONE	RELATIONSHIP
<input type="radio"/> HEARING IMPAIRMENT				
EMPLOYMENT/STUDENT <input type="radio"/> Full Time Student <input type="radio"/> Part Time Student <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Unemployed <input type="radio"/> Self-employed <input type="radio"/> Military Active Duty <input type="radio"/> Retired, Date _____			WORK PHONE	CELL PHONE
EMPLOYER NAME	EMPLOYER ADDRESS	CITY	STATE	ZIP
Income of patients at this Heath Center is a Federal reporting requirement. Thank you for providing this information.				
TOTAL ANNUAL INCOME:			NUMBER OF PEOPLE IN YOUR HOUSEHOLD:	
RESPONSIBLE PARTY INFORMATION (PARENT, GUARDIAN, Guarantor – Complete if applicable)				
NAME FIRST		MI	LAST	RELATION TO PATIENT:
STREET ADDRESS		CITY	STATE	ZIP PHONE
SOCIAL SECURITY NUMBER			DATE OF BIRTH	SEX/GENDER <input type="radio"/> FEMALE <input type="radio"/> MALE
INSURANCE INFORMATION (Medicaid, Medicare, Private insurance card is required)				
<input type="radio"/> NO INSURANCE		<input type="radio"/> MEDICAID, ID #		
<input type="radio"/> PRIVATE INSURANCE Complete Information below		<input type="radio"/> MEDICARE ID#	Do you have an insurance that covers you before Medicare? <input type="radio"/> No <input type="radio"/> Yes, please specify:	
PRIMARY INSURANCE:		COPAY \$	SECONDARY INSURANCE:	COPAY \$
Following information is not required when insurance card is provided				
GROUP/POLICY#	ID#	GROUP/POLICY#	ID#	
Your visit today is covered by: <input type="radio"/> Workman's compensation <input type="radio"/> Liability Insurance <input type="radio"/> Not applicable				
How would you like to be contacted? <input type="radio"/> Home phone <input type="radio"/> Work phone <input type="radio"/> Mail <input type="radio"/> Fax <input type="radio"/> Electronic storage <input type="radio"/> Email _____ <input type="radio"/> No preference				
Primary Caregiver _____			Would you like to register for eServices? <input type="radio"/> Yes <input type="radio"/> No	
Advanced Directive _____			Preferred Pharmacy _____	
Provider of Choice:				
Dr. Moses Young <input type="radio"/>		NP Priscilla Jackson <input type="radio"/>		NP Sharonda Rogers <input type="radio"/>
Dr. Ronald Frye <input type="radio"/>		NP Jennifer Williams <input type="radio"/>		NP Lakeitha Turner <input type="radio"/>
NP Crystal Cook <input type="radio"/>		NP Jermonique King <input type="radio"/>		
Dr. Lee G. Campbell (FAYETTE SITES ONLY) <input type="radio"/>				
I hereby certify that the information shown above is correct.				
SIGNED:		DATE:	WITNESS:	DATE: