Complete & return registration forms BY JUNE 26th!!

RKM Primary Care
Attn: Be Fit Camp
Camp Dates: July 3rd – July 28th

Drop off at RKM Clinton or any of our East Feliciana School Based Health Centers
Email BeFitCamp@RKMCare.org

RKM STAFF
Route any registration forms through interoffice mail to RKM BH, Attn: Amy Garner, Registration at RKM Clinton (x10002)

Packets must be completed in full, including completed physical, **no later than June 26th**

Be Fit and Health Wise: Behavior Contract

The goal of the Be Fit and Health Wise program is to work together to obtain a healthier, more active lifestyle. Campers must adhere to the following expectations in order to achieve this:

I will respect others.

- Campers will show respect toward each other by utilizing encouraging statements and peer feedback.
- Campers will NOT bully, make fun, tease, or taunt other campers.
- Campers will not physically or emotionally harm another camper.

I will be prepared.

- Campers will be ready to have fun and fully participate in all aspects of camp every day.
- Campers will have the appropriate clothing/equipment for the day including:
    - Shorts (at least mid-thigh length), t-shirt or other short sleeved shirt (no spaghetti straps) and sneakers
    - Water bottle
    - Be Fit and Health Wise Camp t-shirt on field trip days (supplied by the program)
- Campers will eat a healthy breakfast prior to arrival.
- Campers will be provided with a snack while at camp.
- Campers will keep up with their own belongings.
- Campers will leave technology at home (tablets, video games, etc.)
    - A phone is acceptable for communication regarding transportation only. Excessive use of a phone will result in the device being confiscated for the day.
- Campers will be well rested.
- Campers will take any medical or psychiatric medications prescribed prior to camp.
- Campers utilizing RKM transportation will be ready to depart the designated site ON TIME.

I will show respect for everyone's wellbeing, the camp facilities and transportation vehicles.

- Campers will stay home when sick in order to prevent the spread of illness.
- Campers understand the Be Fit and Health Wise program has a Zero Tolerance Policy for physical violence, including fighting or other aggressive acts and such behavior will result in the camper being removed from camp for the day and/or summer. Camp Staff will determine if a camper can return.
- Campers understand the Be Fit and Health Wise program has a Zero Tolerance Policy for destruction of property and such behavior will result in the camper being removed from camp for the day and/or summer. Camp Staff will determine if a camper can return. This includes transportation vehicles and the camp facility.
- Campers will not arrive for the Be Fit and Health Wise program prior to 15 minutes before bus picks up and no later than 10 minutes after drop off. Times will be adjusted for field trips.

Camp Registration information

Campers who follow the rules, fully participate, and work hard, will go on field trips (usually on Fridays) and/or participate in special activities each week.

By signing this contract below, I and my parent/guardian fully understand and agree to the terms of this contract.

_____ _____

Participant Signature / Date Parent/Guardian Signature / Date

Be Fit and Health Wise 2023: Registration

Participant Information

First Name: _____ Last Name: _____ Suffix: _____

Sex: _____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: Zip Code: _____

T-Shirt Size: **Youth:** S M L **Adult:** S M L XL 2XL 3XL 4XL

Allergies: _____

Medications: _____

Parent/Guardian Information

First Name: _____ Last Name: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Relationship to participant: _____

Pre-Program Questions

- Have you used any of RKM Primary Care's services before?
  - ❑ Yes ❑ No
- Have you participated in any similar programs before?
  - ❑ Yes ❑ No
- How did you hear about the Be Fit and Health Wise program? (Check all that apply)
  - ❑ Family, friend, or colleague
  - ❑ RKM Primary Care website
  - ❑ RKM Primary Care ad in newspaper
  - ❑ RKM Primary Care Staff
  - ❑ RKM Primary Care Electronic Sign Board
  - ❑ Other (please specify) _____
- How many days a week does the participant exercise? _____
- How long does the participant exercise each day? _____
- What do you and the participant expect from this program:
  - Transportation and Field Trip forms will be sent via email:

Email address: _____

Be Fit and Health Wise: Consent Form

I consent for my child, _____, DOB _____ to participate in the four week ***Be Fit and Health Wise Program*** offered through Primary Care Providers For a Health Feliciana (dba RKM Primary Care).

Be Fit and Health Wise begins on July 3rd, 2023 and ends on July 28th, 2022.

I understand this program includes billable medical and behavioral health sessions; fitness assessments and training; nutritional assessments and nutritional education; self-esteem and behavioral health assessments; body image and other counseling sessions. I understand that my child's insurance will be billed for one health evaluation for clearance to attend the program and at least two behavior health sessions per week.

I understand and agree to pay any out-of-pocket costs due to deductible, co-pay or co-insurance resulting from services provided and billed to insurance. For children without insurance, the costs for these services, along with our sliding fee scale discount program, will be discussed before services are provided.

I give permission for my child to be photographed/video recorded and give ownership and use of photos/videos to Primary Care Providers for a Health Feliciana (dba RKM Primary Care).

_____ _____

Parent/Guardian Signature Date

The attached consent forms, Medical history forms and Be Fit and Health Wise Physical exam must be completed prior to June 26th, 2023.

RKM Registration Information for Be Fit and Health Wise Camp

PATIENT INFORMATION REVIEW/UPDATE

Name: _____ Preferred Name_____ Social Security Number_____
(First Name, Middle Initial, Last Name)

Mailing Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Birth Date _____ Head of Household: _____ Number in Household _____

Student: ☐ Full Time ☐ Part-Time School _____Grade _____

Gender: ▫Male ▫Female	Sexual Orientation: ▫Straight ▫Bisexual ▫Choose not to disclose ▫Lesbian / Gay ▫Something else	Gender Identity: ▫Choose not to disclose ▫Female ▫Male ▫Female to Male/Trans Male ▫Male to Female/Trans Female	Race: (Check all that apply) ▫American Indian ▫Asian ▫Black ▫White ▫Other_____	Ethnicity: Hispanic/Latino Non-Hispanic
Migrant Work Status ▫ Migrant ▫ Seasonal ▫ Not a Farm Worker	Marital Status: ▫Single ▫Married ▫Widowed ▫Divorced ▫Partner ▫Separated	Housing Status: ▫ Not Homeless ▫ Doubling Up ▫ Permanent Supportive Housing ▫ Shelter ▫ Street ▫ Transitional	Primary Language: ▫ English ▫ French ▫ Spanish; Castilian ▫ Other ▫ Refused	Household Income: $ _____ ▫ Weekly ▫ Monthly ▫ Annually

Are you a Veteran? ▫ YES ▫ NO Email Address: _____

Emergency Contact Name_____ Relationship to Patient_____ Phone_____

GUARANTOR INFORMATION (LEGAL GUARDIAN FOR MINOR)

Person Responsible for account_____ Driver License #_____
(First Name, Middle Initial, Last Name)

Relation to Patient _____ Date of Birth _____Soc. Sec. _____

Mailing Address _____ Phone _____

Person Responsible is Employed by_____ Occupation_____

Business Address Business Phone

INSURANCE INFORMATION Is this patient covered by insurance? ▫**Yes** ▫**No**

Insurance Co. Name_____ Insurance Ph. _____

Insurance Co. Address _____ Subscriber Name _____

Relation to Patient _____ Date of Birth _____ Soc. Sec. #_____

Subscriber Address if different from patient's_____

Policy# _____Group # _____

Is this patient covered by additional insurance? ▫Yes ▫No

ADDITIONAL INS. INFO. (SECONDARY OR TERTIARY INSURANCE)

Insurance Co. Name _____ Insurance Phone_____

Insurance Co. Address _____Subscriber Name_____

Relation to Patient _____Date of Birth_____ Soc. Sec. #_____

Policy# _____Group # _____

ASSIGNMENT AND RELEASE

I certify that if I (or my dependent) have insurance I will assign Directly to Primary Care Providers for A Healthy Feliciana, Inc d/b/a RKM Primary Care all insurance benefits, if any, otherwise payable to me for services rendered. **I am financially responsible for all charges, whether paid by the insurance.** I hereby authorize RKM Primary Care to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions. Authorization is granted to release medical information to any physicians or entities to which I may be referred.

Signature	Relationship to patient	Date

CONSENT FOR TREATMENT

_____ _____
Print Patient Name *Patient Date of Birth*

State law requires Primary Care Providers for a Healthy Feliciana, Inc. (PCPFHF) to obtain your consent for treatment. By signing this form, I authorize and direct the providers of PCPFHF, Inc. to treat the patient listed above.

I understand that all PCPFHF locations may participate in one or more Health information Exchanges (HIEs), whereby PCPFHF, Inc. may share health information with my mutual health care providers for treatment, payment or health care operations purposes. Opt-out information is available at www.rkmcare.org.

I understand that PCPFHF Clinics may provide services via Tele–Health electronic media. I understand that such services will be used only for providing necessary services and that the professionals involved will respect and protect the confidential nature of the sessions. I also understand that if I object to the use of any electronic media for use in treatment, it will in no way jeopardize my relationship with PCPFHF Clinics.

I understand that in order to identify patients PCPFHF uses a picture, name and date of birth. PCPFHF may scan a picture ID or take a picture to assist with proper patient identification.

I hereby state that I have read and understood this consent.

_____ _____
Signature of Patient *Date*

If the patient is not able to sign or is a minor, I, the legal guardian or authorized representative of the patient listed above, have read and understood this consent.

_____ _____
Print Name *Relation to Patient*

_____ _____
Signature of Legal Guardian or Relative *Date*

NOTICE OF FINANCIAL RESPONSIBILITY

Pat. Name:_____ DOB_____

Patients:
As a courtesy to you, our facility will bill your insurance plan for services provided. Should your insurance company deny payment for reasons beyond the fault of our facility, then you will ultimately be responsible for any and all charges. This could include out of network charges, non-covered services, deductible balances, and any recoupments of payments due to lack of premium payments. While it is standard practice for this facility to verify coverage ahead of your visit, it is ultimately your responsibility to know if certain services or providers are not covered under your plan. Some visits may take as long as 120 days to collect on from an insurance company. Therefore, any charges denied could be billed to you as late as 120 days or longer past your date of service. It is always recommended that you read Explanations of Benefits (EOB) received from your insurance following a claim that has been filed by us. They will, in most cases, include any balances that may potentially become billable to you. Should you incur any balances for the above reasons, you may apply for our Sliding Fee Discounts. By signing below, you are acknowledging receipt of and understanding of your financial responsibility. Should you have any questions concerning this notice, please see the Practice Manager.

_____ Date_____
Printed Patient Name (Responsible Party if minor)

_____
Patient Signature (Responsible Party if minor)

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)
(May be obtained over the phone.)

In my absence, I authorize the following individual(s) to act on my behalf in seeking treatment for:

_____ _____

(Patient Name) (Date of Birth)

This includes dental treatment and medical treatment, including lab work, injections, immunizations, treatments or procedures, etc. deemed necessary for the patient. At the time of service, medical and/or billing information may be relayed to the individual present with the patient. This person must provide proof of identification.

Authorized persons' name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

It is the responsibility of the patient's parent(s) or legal guardian(s) to keep this form updated with any additions and/or deletions. I understand that this consent will remain in effect until I request otherwise in writing.

_____ _____

Parent/Legal guardian name (print) Parent/Legal guardian (sign)

Effective Date: _____

This form expires one year from the effective date.

If permission obtained via phone:

_____ _____

Relative or Friend with Patient Relationship to Patient

_____ _____

PCPFHF Staff Witness of phone conversation PCPFHF Staff Witness of phone conversation

Patient: _____ DOB: _____

Health History

GENERAL: Check all conditions that the student has:	
❑ Fatigue ❑ Muscle Weakness ❑ Weight Loss ❑ Weight Gain ❑ Eating Disorder ❑ Birth Defects ❑ Mumps ❑ Measles ❑ Chicken Pox ❑ Rheumatic Fever/ Scarlett Fever ❑ Broken bones ❑ History of Anemia ❑ Easy Bleeding/ Bruising ❑ Sickle Cell/trait ❑ Head injuries ❑ Missing Organs: _____ ❑ History of Cancer(list type):_____ ❑ Other Illness (list):_____ ❑ Ever not been allowed to participate in exercise ❑ Dizzy or passed out after exercise ❑ Have/had chest pains during or after exercise ❑	
EYES:	**Date of Last eye exam_____**
❑ Glasses ❑ Contacts ❑ Failing Vision ❑ Eye Pain	
EARS: ❑ Frequent Ear Infections ❑ Perforation of Eardrum	
NOSE: ❑ Hay Fever/ Allergies ❑ Recurrent Nose Bleeds	
MOUTH/DENTAL:	**Last Dental Appointment: _____**
❑ Abscessed Teeth ❑ Mouth Ulcers ❑ Frequent Sore Throats	
LUNGS: ❑ Asthma ❑ Pneumonia ❑ Oxygen Requirement	
HEART: ❑ Irregular pulse ❑ Murmur ❑ Hypertension ❑ High Cholesterol/Triglycerides	
GASTROINTESTINAL: ❑ Diarrhea ❑ Constipation ❑ Irritable Bowel	
GENITOURINARY: ❑ Kidney Failure ❑ Frequent Urinary Tract Infections ❑ Involuntary Excretion of Urine/ Incontinence	
NEUROLOGICAL: Headaches Seizure Disorder	
ENDOCRINE: ❑ Diabetes **LIVER:** ❑ Hepatitis	
CONTAGIOUS DISEASE: ❑ Herpes ❑ HIV ❑ Skin rash	

Hospitalization: Has your child ever been admitted to a hospital? No - Yes If yes: Year _____

Hospital: _____Reason:_____

Surgical History: Has your child had any surgeries: No - Yes If yes, year: _____

Provider: _____Reason:_____

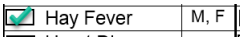
RKM Health information for Be Fit and Health Wise Physical

Patient: _____ DOB: _____

General Family History

Please check all that apply and specify in the column which family member

(M-Mother, F-Father, MGM-Maternal Grandmother, MGF-Maternal Grandfather,

PGM-Paternal Grandmother, PGF-Paternal Grandfather, A-Aunt, U-Uncle) Example: 

Alcoholism		Glaucoma		Cancer		Osteoporosis	
Anemia/ Type		Hay Fever		Diabetes		Seizures	
Arthritis/type		Heart Disease		Epilepsy		Stroke	
Asthma		Hypertension		Hypothroidism/Hyperthyroidism			
Birth Defects		Mental Illness		Other:			
Bleeds Easily		Migraine		Other:			

Allergies:

_____

_____

Medications:

_____

_____

_____

Parent/Guardian: Return these pages to RKM by June 26th, 2023

RKM Staff – schedule the Be Fit and Health Wise Physical when this packet is received, send the packet to:

Amy Garner, Registration, RKM Clinton.

RKM Health information for Be Fit and Health Wise Physical

Be Fit and Healthwise Physical/Approval to Participate

Patient: _____ DOB: _____

I have examined _____ and certify that the patient:

(Patient's Name)

- ❑ IS physically fit to participate in the "Be Fit and Health Wise" program
- ❑ **IS NOT** physically fit to participate in the "Be Fit and Health Wise" program

Comments: _____

_____

_____ _____

Signature of Provider (MD – NP – PA) Date

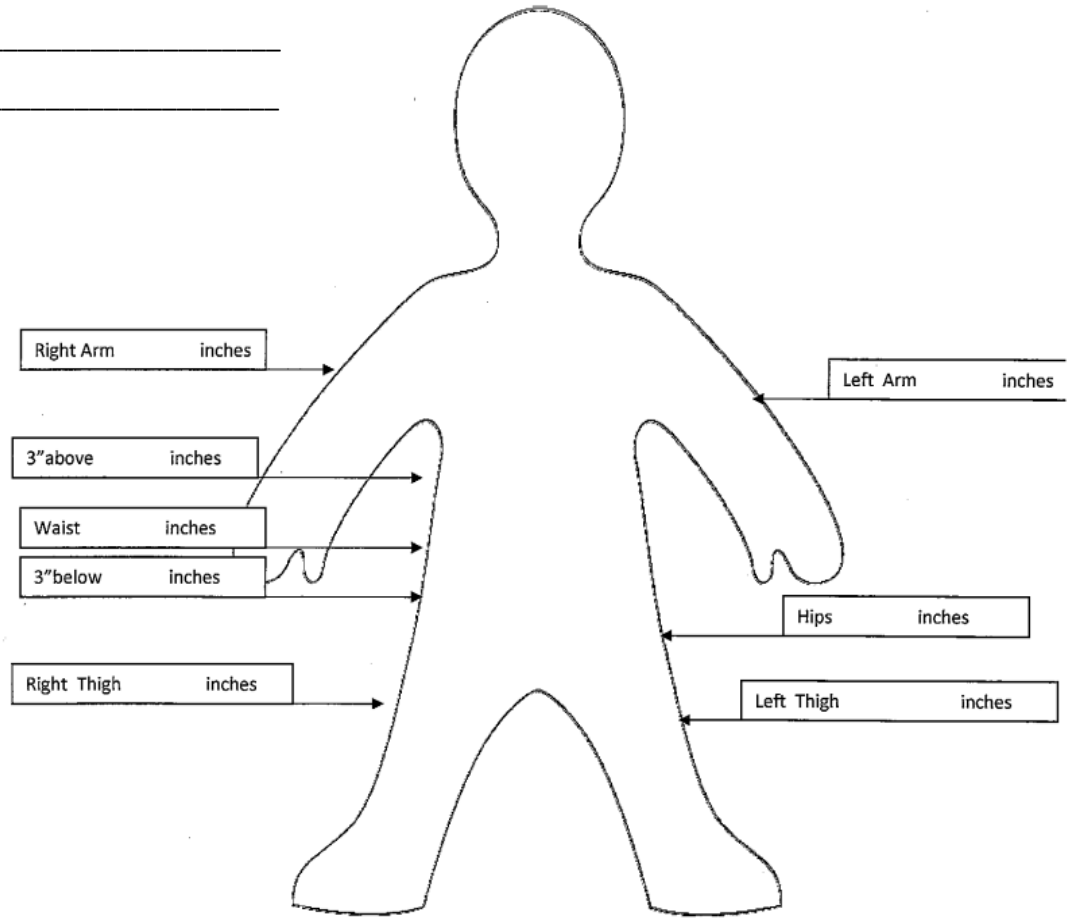
Date Measurements Taken: _____

Height: _____

Weight: _____

Diagnosis: _____

ICD-10 Code: _____



RKM Health information for Be Fit and Health Wise Physical

PARENT/GUARDIAN CHECKLIST

_____ Did you fill out each page of the packet entirely?

_____ Did your child sign the Behavior Contract?

_____ Has the Be Fit Physical been completed and/or scheduled?

_____ Has the Be Fit Behavioral Health Assessment been completed and/or scheduled?