Complete & return registration forms BY JUNE 24th!!

RKM Primary Care
Attn: Be Fit Camp
Camp Dates: July 5th – July 29th

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) or Scan/email to BeFitCamp@RKMCare.org

Packets must be completed in full, including completed physical, **no later than June 24th**

Camp Registration information

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 before 7:45 am and must be picked up by 12:10pm. Times will be adjusted for field trips.

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

Camp Registration information

Be Fit and Health Wise 2022: 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 5th, 2022 and ends on July 29th, 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 24th, 2022.

RKM Registration Information for Be Fit and Health Wise Camp

PATIENT INFORMATION REVIEW/UPDATE

Name: ____ Soc. Sec. #__________________________
(First Name, Middle Initial, Last Name)

Mailing Address_______________________________________ Home Phone_________________________

City, State, Zip____ Cell Phone__________________________

Birth Date________Number in Household ______Employer_____________________

Student: Full Time / Part-Time School ______________________________________Grade _________

Gender:	Sexual Orientation:	Gender Identity:	Race: (Check all that apply)	Ethnicity:
☐Male ☐Female	☐Straight ☐Bisexual ☐Choose not to disclose ☐Lesbian / Gay ☐Something else	☐Choose not to disclose ☐Female ☐Male ☐Female to Male/Trans Male ☐Male to Female/Trans Female	☐American Indian ☐Asian ☐Black ☐White ☐Other__________	☐ Hispanic/Latino ☐ Non-Hispanic
	Marital Status:	Employment Status:	Primary Language:	Household Income:
	☐Single ☐Married ☐Widowed ☐Divorced ☐Partner ☐Separated	☐Full Time ☐Part Time ☐Not Employed/Unemployed ☐Military ☐Retired	☐English ☐French ☐Spanish; Castilian ☐Other ☐Refused	☐0-$11,000 ☐$11,001-$25,000 ☐$25,001-$35,000 ☐$35,001-$50,000 ☐$50,000+

Are you a Veteran? ☐ YES ☐ NO Email Address:_______________________________

Emergency Contact (Friend/relative not living at the same address)_________________________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

Please provide your insurance or medical card so we can make a copy.

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 an additional insurance? ☐**Yes** ☐**No**

ADDITIONAL INS. INFO.

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 RKM Primary Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. **I am financially responsible for all charges whether or not paid by the insurance.** I hereby authorize RKM Primary Care Clinic 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. 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 the information in my medical record will become a part of the Louisiana Health Information Exchange (LaHIE) but not be accessible without my written consent on this form.

Consent for Photography and LaHIE

☐ I consent for photographs to be taken of me or the person(s) for whom I am a legal guardian. I understand that the information may be used in my medical record for identification purposes.

☐ I do NOT consent for photographs to be taken.

☐ I consent for my medical records to be accessed by medical providers with appropriate security clearance through the Louisiana Health Information Exchange (LaHIE).

☐ I do NOT consent for my medical records to be accessed through LaHIE.

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 relative of the patient listed above, have read and understood this consent.

____ ______________________

Print Name *Relation to Patient*

____ ______________________

Signature of Legal Guardian or Relative *Date*

PCPFHF Staff Signature: ___________________________

Policy #MR 001

NOTICE OF FINANCIAL RESPONSIBILITY

Patient. Name:___________________________________ Birth Date: _______________________

Patients:

As a courtesy to you, our facility will bill your insurance plan for services provided today. 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)

____

PCPFHF Registration Staff Signature

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

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.

Policy #MR 002

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:____

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: ☑ Hay Fever | M, F

☐ 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 24th, 2022

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

Amy Garner, Registration, RKM Clinton.

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?

RKM Health information for Be Fit and Health Wise Physical

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 Measures Taken: __________________________________

Height: _______

Weight: _______