Manton Wellness Center

Located Inside
MANTON HIGH SCHOOL
105 5TH ST
MANTON, MI 49663
PHONE: 231-306-3010 FAX: 231-306-5908

PARENT/ GUARDIAN/ CLIENT CONSENT FORM

(Please read and complete front and back)

Student Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Grade:** _____ **School:** _____

SERVICES THAT MAY BE PROVIDED AT THE ADOLESCENT WELLNESS CENTERS (GRADES 6-12)

- Screening/nursing assessments
- Basic lab tests including blood glucose and urinalysis
- Sick Care/ Minor Illness
- First Aid for minor injuries
- Care Coordination for Chronic Illness & Injuries
- Over-the-Counter Medication administration
- Immunization assessment and administration
- Health Education
- Referrals to primary care or specialty services
- *Mental Health Services, Counseling, and Referrals
- *Physical/ Sexual Abuse Counseling and Referrals
- *Substance Abuse Education, Counseling, and Referrals
- *Pregnancy Testing, Counseling, and Referrals
- *Sexually Transmitted Infection Testing, Treatment, and Referrals
- *HIV Testing, Counseling, and Referrals

(*) Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent.

SERVICES NOT PROVIDED:
NO distributing or prescribing of family planning drugs or devices
NO abortion counseling, referrals or services

- I give my consent for the above-named student to receive all services as indicated in this document.

☐ If you do **NOT** want your child to be given any over-the-counter medications (i.e. Tylenol), check this box.

☐ If you do **NOT** want your child to receive immunizations, check this box. Immunizations will not be given without specific written or verbal consent of the parent/guardian. Visit Michigan VIS for the most current Vaccine Information Statements (VIS).

- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above.
- I understand that it is not necessary to renew my consent yearly, but it is necessary to have updated address, phone, insurance, and my child's current health information. I further authorize the Adolescent Wellness Center (AWC) to release information regarding treatment to the following: AWC Staff and its' subcontractors, school staff (when needed to coordinate services at school), and third-party payers when needed for payment of services.
- I understand I may withdraw my consent for services at any time upon prior written notice.
- I authorize both the AWC and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care.
- I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics and have the opportunity to give feedback on services and programs through surveys or focus groups.
- I understand that my child may be administered a behavioral risk assessment (RAAPS) during their appointment at our clinic.
- I understand that testing for bloodborne diseases, including HIV/ AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I understand that services are provided with charges based on the client's income, and I understand that no one will be denied services regardless of ability to pay.
- I understand that my privacy and health information will be handled in a confidential manner as required by the Health Information and Privacy Act (HIPAA) as set forth by DHD #10 (see attached notice).
- I understand that telehealth may be an appropriate service. All existing laws that apply to face-to-face services also apply to telehealth.
- I understand reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth.
- I understand telehealth can include consultation, treatment, transfer of medical/mental health data, emails, telephone conversations and/or education using interactive audio, video, or data communications.
- It is not within the counselor's scope of practice to complete custody evaluations. Therefore, counselors will not be testifying in custody cases.

SIGNATURE OF PARENT/GUARDIAN/SELF: _____ **DATE**: _____

Office Use Only:
PH#: _____

RETURN TO: *The Wellness Center* **(Turn Over and Complete)**

ADOLESCENT WELLNESS CENTER
Registration/ Billing Information
Demographic Information

Student Name	**Birthdate**	**Race** ☐Caucasian/White ☐Black/African American ☐Asian ☐Native Hawaiian/Pac Islander ☐Multi-Racial **Ethnicity** ☐Arab ☐Hispanic ☐Non-Arabic/ Hispanic

Address	**City**	**Zip Code**	**Student Cell #**

Parent/ Guardian	**Relationship to Student**	**Parent Phone #**	**Parent Work Phone #**

Emergency Contact	**Relationship to Student**	**Phone #**

Does Student live with parents? _____ Yes _____ No If not, where? _____

INSURANCE *Please, fill out completely. (see below)**

_____ None/Uninsured (please contact me to help obtain MI Child/ Healthy Kids health insurance for my child) _____Yes _____ No

_____ Medicaid/ MI Child _____ Blue Cross/ Blue Shield _____ Priority _____ Other: _____

_____ MI Health (Student's Card Number: _____)

Policy #	**Group #**

Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**

Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** _____ **Yes** _____ **No**

SECONDARY INSURANCE (if applicable)

_____ Medicaid/ MI Child _____ Blue Cross/ Blue Shield _____ Priority _____ Other: _____

Policy #	**Group #**

Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**

Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** _____ **Yes** _____ **No**

*** PLEASE NOTE: SERVICES ARE NOT DENIED BASED ON INABILITY TO PAY.**
**** PLEASE COPY FRONT AND BACK OF INSURANCE CARD(S) AND RETURN IT WITH THIS FORM.**

Parent/Guardian/Self Initials _____

CLIENT MEDICAL HISTORY

NAME OF PRIMARY CARE PROVIDER:	DATE OF LAST PHYSICAL EXAM: MONTH: YEAR:	DATE OF LAST DENTAL EXAM: MONTH: YEAR:
MEDICATION ALLERGIES: ☐YES ☐NO TYPE:	OVERNIGHT HOSPITALIZATIONS: ☐YES ☐NO REASON:	MEDICATIONS (prescription, over the counter, and/or vitamins): ☐YES ☐NO NAMES AND DOSAGES: _____ _____ _____ _____
FOOD ALLERGIES: ☐YES ☐NO TYPE:	SURGERIES: ☐YES ☐NO TYPE:	
ALLERGIES (i.e. dust, pollen, etc.): ☐YES ☐NO TYPE:	BROKEN BONES: ☐YES ☐NO DESCRIBE:	
BEE STING ALLERGY? ☐YES ☐NO	PREFERRED PHARMACY:	

ADD/ADHD ☐YES ☐NO	ASTHMA ☐YES ☐NO	DIABETES (high blood sugar) ☐YES ☐NO
LD/ SPECIAL NEEDS ☐YES ☐NO IEP ☐YES ☐NO 504 ☐YES ☐NO	HEADACHES/ MIGRAINES ☐YES ☐NO	CANCER ☐YES ☐NO
	HEART PROBLEM ☐YES ☐NO	STOMACH PROBLEMS ☐YES ☐NO
SEIZURE ☐YES ☐NO	MURMUR ☐YES ☐NO	KIDNEY/ URINARY PROBLEMS ☐YES ☐NO
ECZEMA/ RASHES ☐YES ☐NO	HYPERTENSION (high blood pressure) ☐YES ☐NO	DEPRESSION ☐YES ☐NO
ANEMIA (low iron/ blood count) ☐YES ☐NO	FAINTING ☐YES ☐NO	ANXIETY ☐YES ☐NO
OTHER (please specify):	DOES YOUR CHILD SEE A MENTAL HEALTH THERAPIST? ☐YES ☐NO	

Additional Information:

_____

_____

FAMILY MEDICAL HISTORY

☐YES ☐NO	ASTHMA/ EMPHYSEMA/ COPD	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HYPERTENSION (high blood pressure)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HIGH CHOLESTEROL	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	CANCER (please specify type)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	DIABETES (high blood sugar)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	STROKE	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	SEIZURES	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	KIDNEY PROBLEMS	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HEART PROBLEMS	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	MENTAL HEALTH CONCERNS (please specify)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	DEATH UNDER AGE 50 CAUSE:	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	OTHER	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:

Additional Information:

_____

_____

RESOURCE ASSISTANCE

WOULD YOU LIKE INFORMATION FROM OUR STAFF REGARDING THE FOLLOWING? -OPTIONS FOR HEALTH INSURANCE? ☐YES ☐NO -FINDING A HEALTH CARE PROVIDER? ☐YES ☐NO (doctor or nurse practitioner) -FINDING A DENTIST? ☐YES ☐NO	WOULD YOU LIKE MORE INFORMATION REGARDING MENTAL HEALTH SERVICES FOR YOUR CHILD? ☐YES ☐NO ARE YOU CONCERNED ABOUT YOUR INCOME MEETING THE BASIC NEEDS OF YOUR FAMILY? ☐YES ☐NO Please circle concerns: ☐FOOD ☐CLOTHING ☐HOUSING ☐TRANSPORTATION TO MEDICAL OR SCHOOL APPTS ☐HEAT/WATER BILLS **IF YOU ANSWERED YES TO ANY OF THE ABOVE, A MEMBER OF OUR STAFF MAY CONTACT YOU.**

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

For office use:

Reviewed with client: _____ DATE: _____

The Adolescent Wellness Center is operated by District Health Department #10 with major funding from the Michigan Departments of Health and Education.

DISTRICT HEALTH DEPARTMENT #10 CLINIC SIGNATURE FORM

Patient Name: _____ **Birthdate:** _____

I give my permission to District Health Department #10 to release my medical information to my medical insurance provider as required for billing purposes.
If your service(s) are not a covered benefit under your insurance plan, and you have not met your deductible and/or co-pays or are out of network, you will be billed for the cost of service(s) and/ or administration fees as directed by the state of Michigan.
I acknowledge receiving a current Notice of Privacy Practices on _____ from District Health Department #10.
(date)

IMMUNIZATION CLIENTS:
I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. If your service(s) are not a covered benefit and you are eligible for the VFC program (Vaccines for Children), you will be billed the administrative fee only.

I understand that the notice contains my rights and the Health Department's responsibilities with regard to my protected health information. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific service(s) and I ask that the service(s) I have requested be given to me, or the person named above for whom I am authorizing to make this request and I ask that the administration of the service(s) be recorded.

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

*For more information about the GLHC, and your rights associated with the transmission of your information through this and other health information exchanges, please contact Christine Lopez via email: clopez@dhd10.org

District Health Department #10
Healthy People, Healthy Communities

Date	
PH#	
Location	

Declaration of Income & Consent

I affirm that all income, insurance, and payor information provided to District Health Department #10 is accurate and current. I further declare that I have read and understand all the content regarding consents below.

CONSENT FOR CARE

I consent to become a client or consent to my minor child to become a client of the District Health Department #10 (DHD#10). I understand that DHD#10 has a variety of programs for which I may be eligible, and that some of these programs have their own specific consent forms. I acknowledge that I am advised to remain in the clinic for fifteen minutes following treatment for observation of a possible adverse reaction to medications. I do not hold this agency nor its agents responsible in the event of an adverse medication reaction.

I understand that services offered by DHD#10, are confidential and that my information will not be disclosed without my consent, except when required by law. General information may be used for statistical purposes only. I understand that DHD#10 maintains an electronic record of the care and services I receive at DHD#10, as well as at any of its divisions, departments, or partner companies. My records from each DHD#10 program may be combined. DHD#10 needs this record to provide me with the best care possible and to comply with certain legal requirements.

DHD#10 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHD#10 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHD#10:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters or visual aids
- Provides free language services to people whose primary language is not English, such as
- Qualified interpreters
- Information written in other languages

I understand that my Electronic Medical Records can be accessed by all DHD#10 providers.

I further understand that DHD#10, from time to time, contracts with third-party health care providers to provide the most complete services to its clients. These health care providers may have access to my DHD#10 medical records, to the minimal extent necessary to provide services to me at DHD#10.

CONSENT TO RELEASE MEDICAL RECORDS AND INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE OR PAYMENT FOR MY CARE

I authorize DHD#10 and its employees to release information from my financial or medical records to any person, organization, employer (if work-related injury), or review agency which is legally or contractually responsible or which DHD#10 reasonably thinks may be responsible for payment of my bills for my medical care. I further authorize DHD#10 to release information from my medical records to auditors and consultants who are advising DHD#10 on third party payor billing issues and/or assisting DHD#10 in preparing financial data and related documents. I understand that DHD#10 will maintain the confidentiality of my medical records, but I also understand that DHD#10 is not responsible for any breaches of confidentiality of my medical records caused by other parties. This permission includes information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immunodeficiency Syndrome), HIV infection or ARC (AIDS related complex) and includes social work/client communication and psychologist/client communications.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize DHD#10 to bill all insurance payors and hereby assign to DHD#10 all my insurance and managed care benefits due to me for services rendered to me by DHD#10. I request that payment of the authorized benefits from those sources be made on my behalf to DHD#10 and authorize my insurance company and/or my managed care company to make payment directly to DHD#10. I understand that DHD#10 submits claims to insurance carriers as a courtesy to patients and that I am responsible for the balance owed unless DHD#10 has agreed with the payor not to balance bill. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any third-party payor, unless other arrangements are made in advance, to pay my account in full upon discharge from DHD#10; to pay any legal fees and interest at the legal rate, which result due to my not paying my balance. I understand that DHD#10 accepts no liability for failure to meet any pre-cost certification required by my insurance carrier, and I agree that I have, or will, properly execute such certification.

CONSENT TO OBTAIN INFORMATION/RECORDS

I authorize DHD#10 to obtain my information or records to or from hospital, health care providers, insurance companies, service agencies, auditors, or others involved in my care that may be pertinent to the delivery, coordination, and evaluation of my care. This includes all information about my status related to any medical condition(s), including HIV infection. I understand that such records and information include those that identify my name.

CONSENT RELATED TO PRIVACY NOTICE (ALSO KNOWN AS HIPAA)

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights for privacy with respect to your health care information.

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

AFFIRMATION & SIGNATURE

I have read this consent form or have had it read to me. I have been able to ask questions and have been given answers to my questions. I also understand that a copy of this consent form can be given to me if I request a copy.

My signature is sign of consent.

Patient Signature	*Interviewer Signature*	*Interpreter Signature*
Date	*Date*	*Date*
Patient Name	*Interviewer Name*	*Interpreter Name*

Run our organization:
We can use and share your health information to run our health care operations, improve your care, and contact you when necessary. **Example:** *We may use information to review the quality of care you receive.*

Bill for our services:
We can use and share your health information to bill and get payment from health plans or other public or private entities. **Example:** *If you have Medicaid, we will need to disclose your health information to the Medicaid Program in order to be reimbursed for our services.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. **For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests.
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes, or with a law enforcement official with health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. **For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/ consumers/noticepp.html**

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights by contacting :
  Records & Privacy Officer
  DHD#10 - Finance
  PO Box 850
  White Cloud MI 49349
  231-689-7300
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
  200 Independence Avenue S.W.
  Washington, D.C. 20201
  or by calling 1-877-696-6775, or visiting
  www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. This notice was published and became effective on February 1, 2014.

District Health Department #10
Healthy People, Healthy Communities

District Health Department #10
Healthy People, Healthy Communities

Notice of Privacy Practices

Your Information Your Rights Our Responsibilities

Our Privacy Commitment to you

We at the Health Department take confidentiality and privacy of your Health information very seriously. District Health Department #10 is required, by Federal law, to maintain the privacy of protected health information and to provide you with this notice of legal duties and our privacy practices with respect to your protected health information.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of these with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Only people who have both the need and the legal right may see your information. Unless you give us permission in writing, we will only disclose your information for the purpose of treatment, payment, health care operations, or when we are required by law to do so.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We will never share your information for most sharing of psychotherapy notes unless you give us written permission.

We will never share your information for:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals to provide, coordinate, or manage your health care and related services such as Maternal Support Services or Family Planning Services. **Example:** *A nurse may obtain medical information from you to determine the proper case and services to provide. Our practice may contact you with reminder cards of appointments and/or other services which may benefit your family.*