K-Town Youth Health Center
112 S. Brownson Ave. PO Box 117
Kingsley, MI 49649
Phone: 263-5895 Fax: 263-5800
Email address: ktyhc@gtchd.org Website: www.gtchd.org

(For clients age 18 and older)

Registration / Billing Information

Pt # _____

Client Name	Birth Date	Age	Male □ Female □	School	Grade

Address	City	Zip Code	County	Home Telephone #

Parent/Guardian:	Relationship:	Parent Work Phone #	Parent Cellular #

Name of Emergency Contact	Relationship	Telephone #	Cellular #

Race: **(Please check one or more)**
□ Am Indian/Alaskan □ Black/African American
□ White/Caucasian □ Asian
□ Native Hawaiian/Pacific Islander

Ethnicity: **(Please check one or more)**
□ Arabic □ Hispanic
□ Non-Arabic □ Non-Hispanic

Are you employed? □Yes □ No Where? _____ Weekly hours: _____ Hourly rate:_____

Insurance: □ Medicaid □ BCBS □ Priority Health □ Other:_____ □ No Insurance

Policy #	**Group #**	**Immunization Coverage? □ Yes □ No** **Prescription Coverage? □ Yes □ No** **Laboratory Coverage? □ Yes □ No** **Office co-pay?** _____

Member Name:	Birth Date:

Do you live with your parents? □ Yes □ No If no, where? _____

Your Cell # _____ Can we text you? □ Yes □ No

Your email _____ Can we email you? □ Yes □ No

Name of Health Care Provider _____

Date of last visit _____

□ Please send a visit summary to my Primary Care Physician as needed.

K-Town Youth Health Center
Consent for Services

IMMUNIZATIONS

Immunization status will be verified at every visit.

I give K-Town Youth Health Center authorization to obtain a copy of my immunization record from the school's office, primary care provider's office, or the County Health Department. I authorize K-Town Youth Health Center to enter my immunizations into MCIR (Michigan Care Improvement Registry). _____ (Patient Initials)

Client Name: _____ Date of birth: _____ Pt #: _____

SERVICES PROVIDED AT K-Town Youth Health Center (KTYHC)

- Physical exams (including comprehensive, school, sports work, camp) which may include vision & hearing tests, basic lab tests, spirometry, etc.
- Treatment for acute & chronic illness & injuries
- Birth control pills or devices & referrals
- Prescription and over-the-counter medications
- Administration of immunizations (as recommended by ACIP) and TB skin testing
- Referrals for specialty services

*Crisis intervention
*Substance abuse education, counseling
*Mental Health and psycho-social assessment, counseling, treatment and referrals
*Pregnancy prevention, testing and referrals
*Sexually transmitted infection testing, treatment, counseling
*HIV education, counseling, testing and referral

I give my consent to receive all provided services listed above at K-Town Youth Health Center. I understand that I may withdraw my consent for services upon written notice to K-Town Youth Health Center.

I authorize the K-Town Youth Health Center to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the K-Town Youth Health Center and my primary care physician to release information to each other for the purpose of continuity and coordination of care. I also authorize Youth Health and Wellness Center and K-Town Youth Health Center (both Grand Traverse County Health Department teen clinics) to share health information as necessary for the continuity and coordination of care if I receive services at both clinics. I understand that over-the-counter and prescription medications may be prescribed and dispensed by clinic staff under the supervision of the Medical Director.

I understand that I may have the opportunity to participate in educational programs related to health and wellness topics, as well as have the opportunity to give feedback on services and programs through questionnaires or focus groups.

I understand that my privacy is of the utmost importance to KTYHC staff and that health information is always handled in a confidential manner as required by law.

I understand I may be administered a behavioral risk assessment during my appointment at KTYHC.

I understand that I have a right to receive a written copy of the K-Town Youth Health Center *Notice of Privacy Practices* which is available at K-Town Youth Health Center.

I understand that the information I have provided on this form will be used to determine eligibility for payment of medical services based on a sliding-fee scale. I further understand that is my responsibility to report any changes in my income or health insurance coverage to K-Town Youth Health Center before each visit.

I authorize the clinic to bill insurance, Medicaid or another 3rd party payer, if applicable. If the services are not paid by the third party payer, I understand I may get a bill in the mail for a discounted rate. If there is no 3rd party payer to bill, I understand payment is due at the time of each visit. I may be billed at a discounted rate if I unable to cover the amount due at the time of service. I understand I will not be denied services, and unpaid balances will not be sent to collections, due to inability to pay.

SIGNATURE OF CLIENT:_____**DATE:**_____

REVIEWED BY: _____**DATE:** _____

Updated 8/8/2014