Youth Health & Wellness Center

880 Parsons Rd., Traverse City, MI 49686 Ph: 922-6416 Fax: 922-6472
Email address: yhwc@gtchd.org Website: www.gtchd.org

(For students less than 18 years old)

Registration / Billing Information

Pt # _____

Student Name	Birth Date	Age	Male □ Female □	School	Grade

Address	City	Zip Code	County	Home Telephone #

Parent/Guardian:	Relationship to Student:	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

Is Student 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:

Does Student live with Parents? □ Yes □ No If no, where? _____

Student Cell # _____ Can we text student? □ Yes □ No

Student email address _____ Can we email student? □ Yes □ No

Student attends: ____ CTC ____ TC High Other: _____

Name of Health Care Provider _____

Date of last visit _____

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

Youth Health & Wellness Center Consent for Services

IMMUNIZATIONS

Immunization status will be verified at every visit. By initialing, I agree to have my child vaccinated if they are due for any recommended or required vaccinations. _____ (Parent initials)

I understand my child will receive Vaccine Information Statements on all vaccinations they receive, or I may review them before hand by visiting the clinic website at: **www.gtchd.org** _____ (Parent initials)

I give Youth Health & Wellness Center authorization to obtain a copy of the above named student's immunization record from the school's office, primary care provider's office, or the County Health Department. I authorize Youth Health & Wellness Center to enter my child's immunizations into MCIR (Michigan Care Improvement Registry). _____ (Parent initials)

Reviewed by: _____ **Date:** _____

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

SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER (YHWC)

- 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
- 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
* Pregnacy testing and referrals
* Sexually transmitted infection testing, treatment and counseling
* HIV education, counseling, testing and referral

**Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent. Information related to these services will be confidential and will not be disclosed without written authorization of the minor unless otherwise required by law such as Child Protective Services and Communicable Disease reporting, or if a life threatening condition is suspected or detected.*

NO birth control pills or devices are dispensed or prescribed at Youth Health and Wellness Center**.**

I give my consent for the above named student to receive all provided services listed above at Youth Health & Wellness Center. By signing this consent form, I certify that I am the legal guardian of the student named above. I understand that I may withdraw my consent for services upon written notice to Youth Health & Wellness Center.

I authorize the Youth Health & Wellness 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 Youth Health & Wellness Center and my child's 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 Care (both Grand Traverse County Health Department teen clinics) to share health information as necessary for the continuity and coordination of care if my child receives 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 my student may have the opportunity to participate in educational programs related to health and wellness topics, as well as have the opportunity to give feed back on services and programs through questionnaires or focus groups.

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

I understand my student may be administered a behavioral risk assessment during their appointment at YHWC.

I understand that I have a right to receive a written copy of the Youth Health & Wellness Center *Notice of Privacy Practices* which is available at Youth Health & Wellness 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 child's responsibility to report any changes in their income or health insurance coverage to Youth Health & Wellness 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 my son/daughter is unable to cover the amount due at the time of service. I understand my son/daughter will not be denied services, and unpaid balances will not be sent to collections, due to inability to pay.

I understand that I may call to talk with the provider about my child's health care at anytime; however, any information regarding confidential services to minors protected by Michigan Law will be excluded, unless there is a release on file allowing the provider to share this information.

SIGNATURE OF PARENT /GUARDIAN: _____ DATE:_____