NORTHWEST MICHIGAN HEALTH SERVICES INC

Intake & Consent Form

Student's Name:_____ Date of Birth: _____ Sex: ☐ M ☐ F

Address:_____ City:_____ State:_____ Zip:_____

Grade:_____ School:_____ Is it ok to leave detailed voicemails? ☐ Yes ☐ No

Legal Guardian Name:_____ Relationship to Patient: _____

Guardian Date of Birth:_____ Phone Number: _____

Legal Guardian Name:_____ Relationship to Patient: _____

Guardian Date of Birth: _____ Phone Number: _____

Name of Patient's Insurance:_____ ID#:_____

Subscriber's Name:_____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Total Annual Family Income. (Please circle appropriate box)

1 member	☐ $0 - $15,960	☐ $15,961 - $23,940	☐ $23,941 - $29,526	☐ $29,527 - $31,920	☐ > $31,920
2 members	☐ $0 - $21,640	☐ $21,641 - $32,460	☐ $32,461 - $40,034	☐ $40,035 - $43,280	☐ > $43,280
3 members	☐ $0 - $27,320	☐ $27,321 - $40,980	☐ $40,981 - $50,542	☐ $50,543 - $54,640	☐ > $54,640
4 members	☐ $0 - $33,00	☐ $33,001 - $49,500	☐ $49,501 - $61,050	☐ $61,051 - $66,000	☐ > $66,000
5 members	☐ $0 - $38,680	☐ $38,681 - $58,020	☐ $58,021 - $71,558	☐ $71,559 - $77,360	☐ > $77,360
6 members	☐ $0 - $44,360	☐ $44,361 - $66,540	☐ $66,541 - $82,066	☐ $82,067 - $88,720	☐ > $88,720

Race (Please circle)

- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race

Are you homeless? ☐ Yes ☐ No

If yes, please circle:

- ☐ Shelter
- ☐ Street
- ☐ Transitional Housing
- ☐ Doubled Up
- ☐ Other (hotels, day-to-day housing)
- ☐ Unknown/none of the above

Ethnicity (Please circle)

Are you Hispanic or Latino? ☐ Yes ☐ No

Do you (the parent or guardian) work in Agriculture?

☐ Migrant Agriculture ☐ Seasonal Worker ☐ Other/No

1. We provide health insurance enrollment assistance to underinsured. Would you like to be contacted about this? ☐ Yes ☐ No
2. Is English your primary language? ☐ Yes ☐ No If No, what language are you best served in? _____

Medical and Health History

Primary Care Provider:_____ Date of Last Well Child Exam: _____

Dental Provider/Dentist:_____ Date of Last Dental Exam: _____

Student's Pharmacy and Location: _____

Medications and Frequency	Past Medical and Surgical History
Allergies and Reactions	**Family History (e.g. asthma, diabetes, cancer, etc.)**

NORTHWEST MICHIGAN HEALTH SERVICES INC

Student Health Center Consent Form

Student's Name:_____ Date of Birth: _____

School:_____

By signing this form, I acknowledge the following:

Consent for Treatment: By signing this form, I consent to my child receiving the following:

☐ **Medical Services:** Routine diagnostic procedures, including but not limited to blood draw, laboratory tests, and administration of medication and to medical treatment rendered by physicians and staff of Northwest Michigan Health Service, Inc. and other health care providers who may be called upon to consult or assist in ***my/my child's*** *care* as judged necessary by the treating provider. I understand that by law, the Michigan Public Health Code, if a Northwest Michigan Health employee or associate receives an open wound, percutaneous, or mucous membrane exposure to ***mine/my child's*** blood or other bodily fluids, ***mine/my child's*** blood may be drawn, and HIV (AIDS) testing may be performed on ***me/my child*** without my prior written consent. **I understand that no contraceptives may be prescribed or dispensed on school property. I understand that abortion counseling, referrals, or services cannot be provided at the Child & Adolescent Health Center.**

☐ **Behavioral Health Services:** Diagnostic and therapeutic treatment performed within a Student Health Center (TCAPS West/MAPS) or E3 Program (TCAPS East/MCC) which are part of Northwest Michigan Health Services, Inc. (NMHSI). Services including but are not limited to individual counseling, family counseling, substance abuse counseling & referral, physical and sexual abuse counseling & referral. I understand that all healthcare information is confidential, including confidentiality between the student, parent/guardian and the therapist. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The CAHC staff will encourage every student to involve his/her parent/guardian in health care decisions. According to Michigan law, students 14 years or older can receive confidential counseling services. They do not need to have parental consent. Under extreme circumstances, a student's right to privacy may be waived. No abortion counseling or referrals can be provided.
I understand NMHSI Student Health Center Staff will release limited information for appointment coordination purposes related to Student Health Center Services to school staff and its subcontractors.

☐ **Sharing Health Information:** Under the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and the Michigan Mental Health Code, a health care provider or agency may use and share most of your health information to provide you with treatment, receive payment for your care, and manage/coordinate your care. However, your consent is required to share certain types of health information with other people you may wish to have involved in your health care.

☐ **Authorization for Payment Agreement:** We participate with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. I authorize any insurance benefits to be paid directly to Northwest Michigan Health Services, Inc. realizing I am responsible for paying for non-covered services.

☐ **Photography Consent:** I give permission to Northwest Michigan Health Services to photograph my child for marketing purposes.

☐ **Privacy Practices Notice:** I acknowledge being offered a copy of the Northwest Michigan Health Service, Inc. Notice of Privacy Practices, which is available at www.NMHSI.org or by request.

If the patient is under the age of 18: Please complete Authorization for Treatment of an Unaccompanied Minor

Authorization for Treatment of Unaccompanied Minor:
☐ **Yes** ☐ **No** I hereby authorize Northwest Michigan Health Services, Inc, to provide Medical and/or Behavioral Health treatment to the unaccompanied above-named minor child.
☐ **Yes** ☐ **No** I hereby authorize Northwest Michigan Health Services, Inc to administer routine childhood immunizations as selected on the following page. I understand that a separate consent will be required for Influenza (flu) and covid vaccines.

If the student is under the age of 18, parent or guardian must sign.

Parent/Guardian Printed Name and Relationship: _____

Signature:_____ **Date:** _____