

Patient Name: _____ D.O.B.: _____

Consent for Services:

School Health Center services may include: ***mental health services** (treatment, assessment, individual, and family counseling); **dental services** at Northeast Health Center (preventative, restorative, and surgical); and ***medical services**, including primary care, treatment for illness and injuries, physical exams, vision/hearing screening, basic laboratory services and tests, medication administration, and education. Please check the box for the services you consent for your child to receive:

Medical: ☐ Yes ☐ No **Dental:** ☐ Yes ☐ No **Mental Health:** ☐ Yes ☐ No

- I have reviewed and understand the services offered by the Center for Family Health School Health Centers. I give consent for my child to receive the services described above until age 18. I understand that services can be provided without my presence. I may withdraw my consent for services at any time upon written notice. Consent is valid at all CFH school sites. Minor children without a signed consent form will not be seen. Exceptions to this include: one-time verbal consent by phone; an emergency threatening life or limb; students who are legally emancipated; legally married; under court order; in the presence of a law officer when the parent cannot be promptly located; and *minor confidential services.
- I understand that certain dental procedures, vaccines, or mental health services may require additional consent forms and signatures in person by a parent/guardian.
- I understand that testing for blood borne diseases, including HIV/AIDS, may be performed on my child without a separate consent in the event that a Center for Family Health employee is exposed to my child's blood or other body fluids.

Agreement to Pay for Services

- I authorize Center for Family Health to release my health information necessary to Medicare, Medicaid, or other insurance carrier, to process claims and further authorize payment of healthcare benefits payable directly to Center for Family Health.
- I understand that Center for Family Health will file and complete the necessary steps to collect my insurance payment.
- I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at the Center for Family Health according to the sliding fee scale. This includes any deductibles or co-payment portions of my bill after insurance payment.

Authorization for Provider's Access, Use and Disclosure of Records and/or Protected Health Information Through Jackson Community Medical Record, L3C

- I acknowledge that the Center for Family Health is participating in a community wide electronic health record system ("EHR System") established by Jackson Community Medical Record L3C ("JCMR") and has obtained a sub-license to use the EHR Software. This means that my provider will create an individual electronic health record for me in the JCMR EHR system which consists of my private health information ("PHI") which will be available electronically to my provider and other healthcare providers and their respective permitted users for purposes of providing healthcare services to me including treatment, payment, and other healthcare operations. Examples of PHI include but are not limited to my name, address, insurance information, payment history, social security number, laboratory and other diagnostic test results or reports, medications, medical history, surgery information, immunization records and any notes kept by my provider or the provider's office related to my care. In order to create the EHR for me, my provider and his permitted users will be required to disclose my PHI to JCMR, who operates and maintains the community wide EHR.
- I understand that it is the intent of the Center for Family Health to hold all of my individually identifiable health information with the utmost level of confidentiality. I authorize and give consent to the Center for Family health, and its permitted users to create and use an EHR which includes disclosing my PHI to JCMR and other healthcare providers who provide me with healthcare services, for my continuing care and treatment, payment, healthcare operations, and as described in each providers privacy notice. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claims on my behalf. I also authorize payment of medical health insurance benefits to be made directly to the Center for Family Health and its designees for services rendered.
- If a JCMR EHR has already been created for me, I consent and authorize the Center for Family Health and its permitted users to access my JCMR EHR for my continuing care and treatment, payment or healthcare operations. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claims on my behalf. I also authorize payment of medical health insurance benefits to be made directly to the Center for Family Health and/or its designees for services rendered.

Privacy Practice Acknowledgement

- I acknowledge that I have been notified of the Center for Family Health's HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.
- I may receive a copy at any time by contacting the Center.

Patient Centered Medical Home (PCMH)

- I acknowledge that I have been given a copy of the Center's PCMH brochure and I understand my rights and responsibilities as a patient of the Center for Family Health.

I verify that I am the legal guardian of the patient/child named above. In signing this form, I am giving consent to the treatment services and terms listed above.

Signature of Parent or Guardian: _____ Date _____

For foster parents signing on behalf of DHHS, this is not consent for surgical procedures or an agreement to pay for services.



Northeast Health Center • 1024 Fleming St • 787-4361
Parkside Health Center • 2400 Fourth St • 788-6812
Jackson High Health Center • 544 Wildwood • 780-0838
Northwest Community Health Center • 6700 Rives Junction Road • 569-3200

Health History Questionnaire

Print Mother/Guardian Birth	Date of Birth	Print Father/Guardian Birth	Date of Birth
Address		Phone Number	
Primary Insurance:	ID Number:	Subscriber Name and DOB:	
Secondary Insurance:	ID Number:	Subscriber Name and DOB:	

MEDICATIONS			
Current Medications:	Dose:	How Often:	Pharmacy:
PAST MEDICAL HISTORY – Please check any that apply to your child			
☐ Bee Sting Allergies ☐ Food Allergies Type: ☐ Hay Fever ☐ Latex Allergy ☐ Medication Allergy ☐ Pet Allergies ☐ Other Allergies Type: ☐ Heart Murmur ☐ High Blood Pressure ☐ Asthma ☐ Breathing Treatments Machine at home? ☐ Yes ☐ No ☐ Shortness of Breath	☐ Sleep Apnea ☐ Bed Wetting ☐ Frequent Urination ☐ Frequent Urine Infections ☐ Kidney or Bladder Problems ☐ ADD/ADHD ☐ Anxiety ☐ Cutting Behavior ☐ Depression ☐ Eating Disorder ☐ Seizures ☐ Frequent Ear Infections Tubes? ☐ Yes ☐ No	☐ Frequent Sore Throats ☐ Headaches ☐ Hearing problems ☐ Nosebleeds ☐ Vision Problems Glasses? ☐ Yes ☐ No ☐ Broken Bone Part of body? ☐ Pain in Joints ☐ Anemia ☐ Cancer Type: ☐ Sickle Cell Disease ☐ Acne	☐ Eczema ☐ Hives/Rash ☐ Warts ☐ HIV ☐ MRSA ☐ RSV ☐ Constipation ☐ Diarrhea ☐ Stomach Pain ☐ Diabetes ☐ Other:
FAMILY HISTORY – Please check if any of the child's family members (mother, father, siblings, other relatives) have ever had any of the following:			
☐ Family History Unknown – Patient Adopted			
Condition:	Who:	Condition:	Who:
☐ Anxiety ☐ Asthma ☐ Alcoholism ☐ Blood Disease ☐ Heart Disease ☐ Cancer ☐ Depression ☐ Diabetes		☐ Hearing Loss ☐ High Cholesterol ☐ High Blood Pressure ☐ Learning Disability ☐ Mental Illness ☐ Migraines ☐ Obesity	
☐ Renal/Kidney Disease ☐ Seizure Disorder ☐ Sickle Cell Disease ☐ Stroke ☐ Substance abuse ☐ Thyroid Disease ☐ Tuberculosis ☐ Other			
Deceased:	Cause of Death:		Age at Death:
☐ Patient Mother ☐ Patient Father ☐ Patient Sister ☐ Patient Brother	Mother _____ Father _____ Sister _____ Brother _____		Mother _____ Father _____ Sister _____ Brother _____

Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Note: In accordance with Michigan legal requirements, parental consent is not required for outpatient mental health services for individuals age 14 and older, for minors to receive a diagnosis/ medical treatment for a venereal disease or HIV, or a diagnosis of pregnancy or related prenatal care. These services are in accordance with MCLA (Michigan Compiled Laws Annotated) 333.9132, 333.5127, 333.1707