Consent to Treat, Assignment of Benefits, and Authorization to Release Information
Community Adolescent Health Center

Patient Name: _____

Consent to Treatment: I, the undersigned, herby consent to and authorize all diagnostic and therapeutic treatment performed at Northwest Michigan Health Services, Inc. (NMHSI) if considered necessary or advisable in the judgment of NMHSI providers. I understand and consent to a blood draw (including but not limited to HIV, AIDS and hepatitis antibodies) if an employee or provider has had an accidental exposure to my body fluids. I understand that I can obtain the results of these tests from my provider who can explain them. I authorize release of data necessary to process the testing and insurance claim, and I understand there will be no costs to me for this test.

School Based Community Center: NMHSI School Based Health Center includes **Medical, Mental Health, Referral to Community Health Worker. Medical Services**, including: primary care; treatment for illness and injuries; physical exams for school, sports, and camp; basic laboratory services; referral for specialty health services; student health assessment, education and risk reduction programs; chronic disease management; sexually transmitted disease testing and prevention; HIV counseling and testing; immunizations; medication administration; vision/hearing screenings. **Mental Health Services** will consist of the following: treatment, assessment, and individual counseling. **Community Health Worker (CHW)** will act as a community resource connector offering programs to assist those in need, including Medicaid Enrollment. I understand that NMHSI School Based Health Center Staff will have access to view records, including PowerSchool system. I understand NMHSI School Based Health Staff will release limited information to school staff and its subcontractors for appointment coordination purposes related to School Based Health Services.

Assignment of Benefits: I hereby assign all medical and/or behavioral health benefits to which I am entitled, to NMHSI for services provided. This includes Medicaid, Medicare, private and group insurance, or other health plans. I also understand that if I do not assign benefits, I may be responsible for the full charge of all services.

Financial Responsibility: I accept ultimate financial responsibility for accounts with Northwest Michigan Health Services, Inc., whether paid by insurance or not. I understand any change in treatment may alter expected reimbursements from insurance and that the services of providers and other healthcare professionals may be billed separately from those of this facility. As a patient of Northwest Michigan Health Services, Inc. I consent to services for either the prevention of medical or for care of ones that exist. I accept responsibility to pay for this care according to the fees established.

Release of Information: I agree that NMHSI may disclose my medical or behavioral health records to any third party payers, including, but not limited to, health insurers, health care service plans, welfare agencies, and worker's compensation carriers. NMHSI will follow federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and the Michigan Mental Health Code. I am aware and agree that NMHSI and referring providers are authorized to share information with each other including financial and/or medical/behavioral health records, information related to drug use, alcoholism, psychiatric care, or other diagnoses that may be concerned sensitive by some. This may be verbal or written information and the information may include name, age, sex, address, social security number, and dates of professional services provided. I agree to participate in Carequality, by allowing the exchange of my health records with other participating Carequality entities for continuation of care. I may review the information disclosed upon reasonable notice. This consent for release of medical, behavioral health, or financial information is subject to revocation at any time, except to the extent that action has already been taken.

HIPAA Compliance: I authorize NMHSI and/or any entity authorized by NMHSI including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address, and/or mailing address associated with my account.

Notice of Patient Privacy Practices: The Notice of Patient Privacy Practices and the Patient Rights and Responsibilities are posted on our website at www.nmhsi.org for patients to review. Personal copies are also available by request. By signing below, I acknowledge that I have been made aware of the Notice of Patient Privacy Practices and the Patient Rights and Responsibilities for my review and have been offered a personal copy.

I have reviewed and understand the services offered by NMHSI School Based Health Center. I give consent for my child to receive Medical, Mental Health, Referral for CHW described above until the age of 18. By signing this, I understand an attempt to notify me will occur regarding services provided (excluding confidential services). Minor children under the age of 18 must have a written parental consent on file however, a one-time verbal consent by phone from parent/guardian will be accepted per approved policy. *Exceptions to this include confidential services, an emergency threatening life or limb, students who are legally emancipated, students who are legally married, under court-order, in the presence of a law officer when the parent cannot be promptly located, or members of the U.S. Armed Forces.*

_____	_____	_____	_____
Signature of Parent/Guardian/Patient age 18 and older	Print Name	Relationship	Date

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 sexually transmitted infection or HIV, or a diagnosis of pregnancy or related prenatal care. This District will provide these services in accordance with MCLA 333.9132, 333.5127, 333.1707