Intake & Consent Form

Student's Name:_____ Date of Birth: ____/____/____

Address:_____City:_____State:_____ Zip:_____

Grade:_____School:_____ Male_____ Female _____

Legal Guardian Name:_____Relationship to Patient: _____

Guardian Date of Birth:____/____/____Phone: _____

Legal Guardian Name:_____Relationship to Patient: _____

Guardian Date of Birth: ____/____/____ Phone Number: _____

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

Insurance Address:_____Insurance Phone Number: _____

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

Subscriber's Social Security Number: _____

Total Annual Family Income. (Please circle appropriate box)

1 member	$0 - $15,060	$15,061 - $22,590	$22,591 - $27,861	$27,862 - $30,120	> $30,121
2 members	$0 - $20,440	$20,441 - $30,660	$30,661 - $37,814	$37,815 - $40,880	> $40,881
3 members	$0 - $25,820	$25,821 - $38,730	$38,731 - $47,767	$47,768 - $51,640	> $51,641
4 members	$0 - $31,200	$31,201 - $46,800	$46,801 - $57,720	$57,721 - $62,400	> $62,401
5 members	$0 - $36,580	$36,581 - $54,870	$54,871 - $67,673	$67,674 - $73,160	> $73,161
6 members	$0 - $41,960	$41,961 - $62,940	$62,941 - $77,626	$77,627 - $83,920	> $83,921

Ethnicity (Please circle)

Are you Hispanic or Latino? ☐ Yes ☐ No

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 (homeless/none of the above)

1. We provide enrollment assistance to uninsured and underinsured to obtain health insurance. Would you like us to contact you about this? _____Yes _____No

2. Is English your primary language? _____Yes _____No

   If no, what language are you best served in? _____

Medical and Mental Health History

Name of Primary Care Provider:_____Telephone: _____

Name of Student's Pharmacy and Location: _____

Medications	Dose	Frequency	Dose

Date of Last Well Child Exam: _____

Student Name: _____

Allergies	Reaction and Severity

Student and Family History: List any chronic health conditions and student surgical history below

By signing this form, I acknowledge the following:

☐ **Consent for Treatment:** I consent to 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.**

☐ **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.

☐ **Behavioral Health Services**: I acknowledge that behavioral health services are available upon request. These services include 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. Confidentiality between the student, parent/guardian and the therapist are assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The MAPS Health Center staff will encourage every student to involve his/her parent/guardian in health care decisions.

☐ **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 to pay non-covered services.

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 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 childhood immunizations excluding Influenza (flu) and covid vaccines. I understand that a separate consent will be required for Influenza (flu) and covid vaccines.

Parent/Guardian Printed Name and Relationship: _____

Signature: _____ **Date:** _____

(If under 18, must be signed by parent or guardian)