

# 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 - \$15,650	\$15,651 - \$23,475	\$23,476 - \$28,953	\$28,954 - \$31,300	> \$31,300
2 members	\$0 - \$21,150	\$21,151 - \$31,725	\$31,726 - \$39,128	\$39,129 - \$42,300	> \$42,300
3 members	\$0 - \$26,650	\$26,651 - \$39,975	\$39,976 - \$49,303	\$49,304 - \$53,300	> \$53,300
4 members	\$0 - \$32,150	\$32,151 - \$48,225	\$48,226 - \$59,478	\$59,479 - \$64,300	> \$64,300
5 members	\$0 - \$37,650	\$37,651 - \$56,475	\$56,476 - \$69,653	\$69,654 - \$75,300	> \$75,300
6 members	\$0 - \$43,150	\$43,151 - \$64,725	\$64,726 - \$79,828	\$79,829 - \$86,300	> \$86,300

<p><b>Ethnicity (Please circle)</b> Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Race (Please circle)</b> Asian Native Hawaiian Other Pacific Islander Black African American American Indian/Alaska Native White More than one race</p>	<p><b>Are you homeless?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes, please circle:</b> Shelter Street Transitional Housing Doubled Up Other (hotels, day to day housing) Unknown (homeless/none of the above)</p> <p><b>Do you (the parent or guardian) work in Agriculture?</b> <input type="checkbox"/> Migrant Agriculture <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> None</p>
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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.NMHHSI.org](http://www.NMHHSI.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:** \_\_\_\_\_

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

**Date:** \_\_\_\_\_