Center for Family Health

Treatment Agreement
School Health Centers

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

Consent for Services:

School Health Center services may include: ***mental health services** (treatment, assessment, individual, and family counseling); ***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 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 vaccines, certain medical procedures, 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 Community Health Technology Network, L3C

- I acknowledge that the Center for Family Health is participating in a community wide electronic health record system ("EHR System") established community Health Technology L3C ("CHTN") 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 CHTN 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 CHTN, 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 CHTN 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 CHTN EHR has already been created for me, I consent and authorize the Center for Family Health and its permitted users to access my CHTN 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.

Center for Family Health

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 Date of Birth		Print Father/Guardian 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	□ Sleep Apnea	□ Frequent Sore Throats	□ Eczema
□ Food Allergies Type:	□ Bed Wetting	□ Headaches	□ Hives/Rash
□ Hay Fever	□ Frequent Urination	□ Hearing problems	□ Warts
□ Latex Allergy	□ Frequent Urine Infections	□ Nosebleeds	□ HIV
□ Medication Allergy	□ Kidney or Bladder Problems	□ Vision Problems	□ MRSA
□ Pet Allergies	□ ADD/ADHD	Glasses? □ Yes □ No	□ RSV
□ Other Allergies Type:	□ Anxiety	□ Broken Bone	□ Constipation
□ Heart Murmur	□ Cutting Behavior	Part of body?	□ Diarrhea
□ High Blood Pressure	□ Depression	□ Pain in Joints	□ Stomach Pain
□ Asthma	□ Eating Disorder	□ Anemia	□ Diabetes
□ Breathing Treatments	□ Seizures	□ Cancer Type:	□ Other:
Machine at home? □ Yes □ No	□ Frequent Ear Infections	□ Sickle Cell Disease	
□ Shortness of Breath	Tubes? □ Yes □ No	□ Acne	

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:	Condition:	Who:
□ Anxiety		□ Hearing Loss		□ Renal/Kidney Disease	
□ Asthma		□ High Cholesterol		□ Seizure Disorder	
□ Alcoholism		□ High Blood Pressure		□ Sickle Cell Disease	
□ Blood Disease		□ Learning Disability		□ Stroke	
□ Heart Disease		□ Mental Illness		□ Substance abuse	
□ Cancer		□ Migraines		□ Thyroid Disease	
□ Depression		□ Obesity		□ Tuberculosis	
□ Diabetes				□ Other	

Deceased:	Cause of Death:	Age at Death:
□ Patient Mother	Mother_____	Mother_____
□ Patient Father	Father_____	Father_____
□ Patient Sister	Sister_____	Sister_____
□ Patient Brother	Brother_____	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 Complied Laws Annotated) 333.9132, 333.5127, 333.1707