Family Medical Center of Michigan, Inc.

8765 Lewis Avenue

Temperance, Michigan 48182

http://www.familymedical.org

To Parent(s) and/or Guardian(s):
Family Medical Center of Michigan's Child and Adolescent Health Center (CAHC) gives your child an opportunity to be seen by a licensed healthcare provider without having to leave their school. An explanation of the services offered by the school-based health center is listed below. You do not have to be present for your child to be seen for behavioral health care follow up visits or most primary care visits; however, a consent form must be signed by you before services will be provided. For behavioral health counseling, **both parents/guardians must attend the intake appointment in person**.

Description of Services

- Primary care treatment services (available at select school-based health center locations only)
- Psychiatric services via tele-health through Family Medical Center (FMC)
- Behavioral Health Screening and Assessments
- Psychoeducation
- Brief-solution focused strategies for symptom and stress management, and improved coping skills
- Insurance enrollment assistance for adolescents that are uninsured or underinsured.

Your insurance will be billed for services provided in the school-based health center. If you do not have insurance, services will be provided on a sliding fee scale that is based on the student's income. Please contact us if you have any questions or concerns at the following number: (734) 847-3802**.**

Crisis interventions and emergency care do not require consent. Life-saving interventions MAY be initiated without prior consent. Services NOT provided at school-based health clinics include dispensing contraception and abortion counseling.

Current Michigan Law mandates (requires) confidential services to be available to minors in these areas: pregnancy, sexually transmitted infections (STI) and human immunodeficiency virus (HIV) testing and counseling, behavioral health counseling, substance abuse counseling.

Family Medical Center Staff

The health center works with, and is not meant to replace, your family doctor. Our staff is here to assist you, and we are available to communicate with the parents of each student. We want to know your concerns and be able to keep you updated on your student's health. In some circumstances, State Law mandates confidentiality. Feel free to contact us during office hours with any questions.

The attached forms must be completed and returned to the school staff before your child can be seen at the school-based health center. Thank you.

SCHOOL-BASED HEALTH CENTER ENROLLMENT, HEALTH HISTORY & CONSENT FORM

PATIENT INFORMATION

Legal Name:_____Preferred Name:_____Gender:____
Date of Birth:_____Grade:_____Social Security #: _____
Address:_____City/State/Zip:_____
Phone:_____Email:_____
Race:_____ Ethnicity:_____Name & Relation of who student/patient resides with: _____

PARENT/GUARDIAN INFORMATION OF MINOR CHILDREN

Father/Guardian's Name:_____DOB:_____Phone (H)_____(C)_____(W)_____
Mother/Guardian's Name: _____ DOB:_____ Phone (H) _____(C) _____ (W)_____
Emergency Contact Name:_____Phone: (H)_____(C)_____ (W)_____
Alternate Contact Name:_____Phone:(H)_____(C)_____(W) _____

Parent Relationship Status: __Married __Divorced__Separated__Other: please explain_____

PATIENT HEALTH INFORMATION

1. List any allergies your child may have and any medications your child should **not** take: _____
   _____
2. List any medications (prescription and/or over the counter) your child currently takes and why: _____
   _____
   _____
3. Family Physician/Pediatrician:_____Phone:_____
4. Date of last doctor's visit & Reason: _____
5. If we need to call in a prescription, which pharmacy would you like us to call? _____
6. Dentist:_____Last dental visit: _____
7. Are vaccinations current? ____ Yes _____No _____Unsure
8. Last Menstrual Period: _____
9. **Medical History:** Please check/circle all that apply for your child:

___ADD/ADHD
___Allergies: Food
___Allergies: Other
___Anemia
___Anxiety
___Asthma
___Depression
___Eating Disorder
___Blood Pressure: High/ Low
___Blood Sugar Problem/Diabetes

___Elimination Problem (explain) _____
___Diarrhea or Constipation
___Epilepsy/Seizure
___Headaches
___Hearing or Vision Problem
___Heart Problems

___Chicken Pox (age)_____
___Other: _____

Describe any of the above responses, indicate current/past treatment for the condition, and treating physician:

_____
_____
_____

Insurance Information

Patient/Student Name:_____**DOB:** _____

Primary Insurance: _____
Person responsible for the Bill:_____Phone:_____
Insurance ID Number:_____Group Number:_____
Name of Subscriber:_____Date of Birth:_____
Address:_____City/State/Zip: _____
Policy Holder's Social Security Number:_____Place of Employment: _____
Patient's Relationship to Subscriber:__SPOUSE____CHILD__OTHER_____SELF

Secondary Insurance: _____
Insurance ID Number:_____Group Number:_____
Name of Subscriber:_____Date of Birth:_____
Policy Holder's Social Security Number:_____Place of Employment: _____
Patient's Relationship to Subscriber: SPOUSE CHILD OTHER SELF
MEDICAID: Please check one___Meridian Health___United Healthcare Community Plan__Other
ID Number:_____Group Number: _____

I authorize Family Medical Center of Michigan to release any information necessary to process any medical claims for services provided to myself or family members covered by my insurance policy or required by regulatory or accrediting organizations. I authorize payment of medical benefits be made directly to Family Medical Center of Michigan.

_____ _____

Signature Date

I understand that I will receive a statement of my account while my insurance is being billed until it has been paid in full by my insurance or myself._____(**Initial)**

I understand that, if my insurance has not paid a claim within 45 days from the date of service, that I am responsible for contacting my insurance company and/or pay the bill myself._____(**Initial**)

I understand that I am responsible for my charges at Family Medical Center of Michigan whether I am self-pay, receiving discounted services, or if my insurance does not pay for the charges incurred at Family Medical Center of Michigan._____(**Initial)**

_____**NO HEALTH INSURANCE:** Request Application for Sliding Scale Fee/MI Child/Medicaid.

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

Patient Acknowledgement of Receipt of Policies and Practices

I hereby acknowledge that I have received a copy of Family Medical Center of Michigan's Notice of Privacy Practices. * Electronic copy available online at:

https://familymedicalmi.org/for-patients/privacy-policy/

_____

Patient Signature Date

_____

Parent or Patient Representative Signature Date

_____

Description of Legal Authority to act on behalf of Patient

I hereby acknowledge that I have received a copy of Family Medical Center's Financial Policies.

_____

Patient Signature Date

_____

Parent or Patient Representative Signature Date

_____

Description of Legal Authority to act on behalf of Patient

Financial Policy

As a courtesy to our patients, Family Medical Center of Michigan will file your insurance claim with your primary insurance carrier. Family Medical Center of Michigan will supply you, upon request, with all pertinent information to assist in the filing of a claim to your secondary insurance carrier, or we will be glad to file those secondary insurance claims for you on a one-time basis.

To alleviate any misunderstanding regarding insurance payments, all patients must assign their primary insurance company directly to Family Medical Center. If you want the primary insurance company to pay you directly, Family Medical Center of Michigan will require full payment prior to service being rendered. Secondary insurance payments filed by Family Medical Center of Michigan must be assigned directly to Family Medical Center of Michigan. You will be responsible for all balances not covered by your primary or secondary insurance company.

Michigan law requires that insurance companies pay medical practices within a reasonable amount of time (45 days). If a problem persists, we will ask you to assist us in contacting your insurance carrier. Your insurance coverage is a contractual relationship between you and your insurance carrier, not Family Medical Center of Michigan and your insurance. Therefore, all claims not paid within a reasonable amount of time (45 days for "clean claims") will become your responsibility, for which you will receive a bill.

All patients must read and sign Family Medical Center of Michigan's written financial arrangement prior to services being rendered. Our staff will make every effort possible to clarify any misunderstanding that should occur concerning account balances.

Family Medical Center of Michigan's goal is to create an excellent physician/patient relationship.

Family Medical Center of Michigan uses the following guidelines regarding financial payment:

1. All Patients must read and sign Family Medical Center of Michigan's financial agreement prior to services being rendered.
2. Insurance payments that have not been received within 60 days after filling will be turned over to the patient's responsibility.
3. Patients will receive a statement of account each month indicating the amount that is the patient’s responsibility. Payment of your balance is due within 30 days

4. If you feel that your insurance company has not paid correctly, it is your responsibility to contact them.
5. For patients who are eligible for Medicare, we are "participating physicians." This means that we accept Medicare's allowed charge for the services rendered, eliminating the difference between what we charge and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for 20% of the approved charge, plus any deductible. If you have secondary insurance, we will submit a claim to them once for any remaining balance after Medicare has paid. Please remember that although we will accept assignment for Medicare patients, the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered Medicare.
6. In cases of divorce, the parent seeking treatment is ultimately responsible for payment of the bill unless we receive legal documentation stating otherwise.
7. No student will be denied services due to outstanding balances.

About Our Notice of Privacy Practices

Family Medical Center is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in the Notice.
- The person to contact for further information about our privacy practice.

Family Medical Center is required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

PARENTAL CONSENT TO TREATMENT FORM TO RECEIVE SERVICES AT THE SCHOOL-BASED HEALTH CENTER

Patient/Student's Name:_____DOB:_____

I, the parent/guardian of said student, give consent for my child to receive all services at the school-based health center, either in person or via tele-health. All services are provided in compliance with federal, Michigan, and Michigan minor consent laws. I understand that this consent form is valid for the entire time enrolled in our school district or until I provide the clinic staff with written directions otherwise. Consent can be withdrawn by submitting a written request to withdraw consent to health center staff.

At a minimum, the following services are provided at the health center. Primary care including health maintenance and care for acute illness and chronic conditions, behavioral health services, confidential services including mental health, pregnancy testing and counseling and contraceptive counseling, immunizations screening and administration with the utilization of the Michigan Care Improvement Registry, STI diagnosis and treatment and HIV counseling and testing as allowed by state and/or federal law, health education and risk counseling, and referral for other needed clinical services not available at the health center.

HIPPA/FERPA: All healthcare information is confidential. By signing the consent form, you are giving the school-based health center permission to communicate and share medical information with your child's primary care doctor regarding your child's medical condition on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner. By signing the consent form, I acknowledge I have been offered a copy of the Notice of Privacy Practices (available at the school nurse's office or the following website: http://www.familymedicalmi.org.

No student will be denied access to healthcare services due to the inability to pay. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing services.

Confidentiality between student, parents and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

In limited circumstances, confidentiality may not be protected. Disclosure of any information that might indicate child physical or sexual abuse or child neglect requires a mandatory report to Child Protective Services. A student report of a plan/intent to harm themselves or others with the means to do so may also necessitate disclosure to keep people safe.

The Child and Adolescent Health Center is PROHIBITED from prescribing birth control, providing contraceptives, and providing any abortion services or referrals for abortion services.

Under Michigan law, patients ages 12 to 17 have the right to the following WITHOUT parental/guardian consent or knowledge:

- Pregnancy testing and prenatal care
- Contraceptive information and referral for reproductive health services
- Testing and treatment for sexually transmitted infections (STI's), including HIV
- Substance use counseling
- Access to confidential mental health counseling, up to 12 visits or 4 months (whichever occurs sooner), for patients ages 14 and up. Mental health medications may not be prescribed without parent/guardian consent.

I understand that it is outside the scope of practice for Family Medical Center therapists to testify in court proceedings having to do with custody, visitation rights, parental fit, or any other circumstances involving legal custody of the child.

Signature of Parent/Legal Guardian	Date
Signature of Parent/Legal Guardian	Date
Staff Signature	Date

Minor Treatment Permission Form

PLEASE NOTE: A NATURAL PARENT OR LEGAL GUARDIAN MUST ACCOMPANY CHILD TO INTAKE APPOINTMENTS AND YEARLY REASSESSMENT APPOINTMENTS.

I, _____, give permission for the following people/person

_____ _____

to bring in_____ _____
Child /Minor Name Child/Minor Date of Birth

- ☐ **My Child (if full/partial custody is split, LEGAL DOCUMENTATION IS REQUIRED)**
- ☐ **Foster Child (LEGAL DOCUMENTATION IS REQUIRED)**
- ☐ **Legal dependent (LEGAL DOCUMENTATION IS REQUIRED)**
- ☐ **Child Under my legal medical care (LEGAL DOCUMENTATION IS REQUIRED)**

- In the circumstances of divorce and legal custody issues, we do require any legal documentation pertaining to your child to be on file with our office. If a change occurs, it is your responsibility to provide us with the documentation of that change. If we do not receive documentation pertaining to custody/guardianship of the child listed above, we will continue to abide by what we currently have on file.
- I understand that it is outside the scope of practice for Family Medical Center therapists to testify in court proceedings having to do with custody, visitation rights, parental fit, or any other circumstance involving legal custody of the child listed above.
- I understand that Family Medical Center of Michigan, under law, has the right to request proof of guardianship, legal medical authority, and proof of identification (photo identification) of any persons listed on this form.

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

Family Medical Center Minor Consent for Treatment

Usually, health care providers/therapists need written permission to provide you care from a parent or guardian. This is called consent for treatment. Under Michigan law, a person ages 12 to 17 years old can receive some medical care and/or mental health care without parental/guardian consent or knowledge. This type of care is:

- Pregnancy testing, basic prenatal care, and referral for reproductive health services
- Testing and treatment for sexually transmitted infections (STI's), including HIV
- Substance use treatment
- Age 14 or older, access to mental health counseling, up to 12 visits or 4 months (whichever occurs sooner).

The Health Center is PROHIBITED from prescribing birth control, providing contraceptives, and providing any pregnancy termination services or referrals for pregnancy termination services.

Health care providers/therapists must override the minor's confidentiality and report if:

- There is suspicion of abuse by an adult
- There is suspicion of abuse of any minor by an adult
- The minor is a risk to themselves or someone else

Health care providers/therapists may notify my parent(s)/guardian without my permission for medical reasons. Health center staff will make every effort to inform me of this prior to talking with my parent/guardian.

Neither you, nor your parent(s)/guardian will be billed for any services you receive. If available, medical insurance may be billed for the care you receive if your confidentiality can be maintained while doing so.

The potential benefits of involving my parent(s) or legal guardian to consent for my care was discussed.

By signing this form, I am asking for and allowing the staff of Family Medical Center of Michigan, using the facilities of the Child and Adolescent Health Center and Family Medical Center of Michigan, to administer allowable primary care (for schools with health centers) and behavioral health treatment deemed necessary and advisable for me. I understand that my confidentiality cannot be guaranteed. All services are provided in compliance with federal, Michigan, and Michigan minor consent laws.

I understand that I have the right to refuse or defer (put off) treatment recommended by the health care provider and/or therapist.

I may withdraw my consent for treatment at any time by giving a written statement to any health center staff. Staff will assist you in writing this statement if you would like some help.

Signature: _____ Date: _____

Print Name_____

NOTICE: I understand that testing for blood borne diseases, including HIV, may be performed without a separate written consent if a health professional, student or employee of Family Medical Center is exposed to the patient's blood or body fluids through the skin, mucous membrane, or open wound, under Michigan la

Family Medical Center School-Based Health Center
New Patient Appointment Checklist

Please return the following items:

- **New Patient Packet-all pages completed**
- **Copy of Current Custody Paperwork-if applicable**
- **Driver's License/State ID (front & back)**
- **Insurance Card (front & back)**

  -If a photo copier is not accessible, photos of both cards can be sent as a text message to the support coordinator assigned to your child's school.

***All items on this checklist must be completed and returned to us before we can schedule a behavioral health intake appointment or see your child for a primary care appointment**