Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

School Based Health Center
Consent for Treatment, Privacy Acknowledgement, Payment Agreement & Questionnaire

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 Number: _____

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	15,061-20,080	20,081-25,100	25,101-30,120	> $30,121
2 members	0-$20,440	20,441-27,253	27,254-34,067	34,068-40,880	> $40,881
3 members	0-$25,820	25,821-34,427	34,428-43,033	43,034-51,640	> $51,641
4 members	0-$31,200	31,201-41,600	41,601-52,000	52,001-62,400	> $62,401
5 members	0-$36,580	36,581-48,773	48,774-60,967	60,968-73,160	> $73,161
6 members	0-$41,960	41,961-55,947	55,948-69,933	69,934-83,920	> $83,920

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? _____

Delegation of Consent for Treatment of Your Child: You may appoint individuals over the age of 18 of age to authorize treatment in your absence. I, being the parent or legal guardian of the above-named minor, do hereby appoint the following individual(s) to act on my behalf in authorizing medical, surgical, care, and hospitalization for my minor child. In no event shall this delegation of parental rights be effective for more than 12 months.

Contact Name: _____ Contact Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Name of Primary Care Provider: _____ Telephone: _____

Name of Student's Pharmacy: _____ Date of Last Well Child Exam: _____

Medical and Mental Health History

Medications	Dose	Frequency	Dose

Allergies	Reaction Severity

Self 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 x-rays, blood draw, laboratory tests, and administration of medication and to medical treatment rendered by physicians and staff of Thunder Bay Community Health Service, Inc. and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating provider. I understand that by law, the Michigan Public Health Code, if a Thunder Bay Community Health Service employee or associate receives an open wound, percutaneous, or mucous membrane exposure to my blood or other body fluids, my blood may be drawn and HIV (AIDS) testing may be performed on me 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 school-based health center.**

Sharing Health Information: Under the Health Insurance Portability and Accountability Act (HIPAA), 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 is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The SBHC 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 Thunder Bay Community Health Service, Inc. realizing I am responsible to pay non-covered services.

Privacy Practices Notice: I acknowledge being offered a copy of the Thunder Bay Community Health Service, Inc. Notice of Privacy Practices which is available at www.tbchs.org or by request.

Guardian Printed Name: _____

Guardian Signature: _____ **Date:** _____

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REV 7/2022, 8/2022, 3/2023