K-TOWN YOUTH HEALTH CENTER
Specializing in Teen Health

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Registration/Billing Information

Pt # _____

(For patients less than 18 years old)

Patient's Name	Date of Birth	Male □ Female □	Preferred Pronouns:	
Address	City	Zip Code	County	Home Telephone #
Parent/Guardian:	Relationship to Patient:	Parent Work Phone #		Parent Cellular #
Name of Emergency Contact	Relationship to Patient:	Telephone #		Cellular #

Race: **(Please check one or more)**
□ Am Indian/Alaskan □ Black/African American
□ White/Caucasian □ Asian
□ Native Hawaiian/Pacific Islander

Ethnicity: **(Please check one or more)**
□ Arabic □ Hispanic
□ Non-Arabic □ Non-Hispanic

Is Patient employed? □Yes □ No Where? _____ Weekly hours: _____ Hourly rate:_____

Insurance: □ Medicaid □ BCBS □ Priority Health □ Other:_____ □ No Insurance

Policy #	**Group #**	**Immunization Coverage? □ Yes □ No** **Prescription Coverage? □ Yes □ No** **Laboratory Coverage? □ Yes □ No**
Member Name:		Birth Date:

Does Patient live with Parent(s)? □ Yes □ No If no, where? _____

Patient Cell # _____ Can we text patient? □ Yes □ No

Patient attends: ____ KHS ____ KMS Other: _____ ____ Not in school

Name of Primary Care Provider _____

Date of last visit _____ Reason for last visit: _____

Date of last Well Child Exam or Comprehensive Physical _____

□ Please send a visit summary to Patient's Primary Care Physician as needed.

SERVICES PROVIDED AT K-TOWN YOUTH HEALTH CENTER (KTYHC)

Services at K-Town Youth Health Center are available to all youth ages 10-21, and their children.
Our services are offered without regard to a patient's sex, race, religion, gender identity or sexual orientation.

- Physical exams (including comprehensive, school, sports, work, camp) which may include vision & hearing tests, basic lab tests, spirometry, etc.
- Treatment for acute & chronic illness & injuries
- Prescription and over-the-counter medications
- Administration of immunizations (as recommended by ACIP) and TB skin testing
- Referrals for specialty services
- Annual health risk assessment

* Crisis intervention
* Substance abuse education, counseling
* Mental Health services
* Pregnancy testing and referrals
* Reproductive health/birth control methods
* Sexually transmitted infection testing, treatment and counseling
* HIV education, counseling, testing and referral

**Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent. Information related to these services will be confidential and will not be disclosed without written authorization of the minor unless otherwise required by law such as Child Protective Services and Communicable Disease reporting, or if a life threatening condition is suspected or detected.*

Patient Name: _____ Date of birth: _____ Pt # _____

By signing this consent form, I give me consent for the above named patient to receive all provided services listed above at K-Town Youth Health Center. Further, I certify that I am the legal guardian, parent, or representative of the patient named above. This consent will not expire and I understand that I may withdraw my consent for specific service and/or all services at any time by notifying a KTYHC staff member and written notice may be requested.

I understand that over-the-counter and prescription medications may be prescribed and dispensed by clinic staff under the supervision of the Medical Director.

I understand that immunizations/vaccines are given in accordance to the recommendations of ACIP which include HPV, Hepatitis A, and Meningitis B.

I authorize the KTYHC to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the KTYHC and my child's primary care physician to release information to each other for the purpose of continuity and coordination of care.

I authorize Youth Health and Wellness Center and K-Town Youth Health Center (both Grand Traverse County Health Department teen clinics) to share health information as necessary for the continuity and coordination of care if my child receives services at both clinics.

I authorize the KTYHC to release information regarding appointments to my child's school when needed to coordinate services at school. I understand that I may revoke this authorization at any time by contacting the clinic by phone or in writing. A separate release of information is needed to disclose information beyond appointment time and status.

I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics, as well as have the opportunity to give feed back on services and programs through questionnaires, focus groups, or the Student Advisory Committee.

I understand that my/my child's privacy is of the utmost importance to KTYHC staff and that health information is always handled in a confidential manner as required by law.

I understand my child may be administered a behavioral risk assessment during their appointment at KTYHC.

I understand that I have a right to receive a written copy of the Grand Traverse County Health Department *Notice of Privacy Practices* which is available at KTYHC.

I understand that the information I have provided on this form will be used to determine eligibility for payment of medical services based on a sliding-fee scale. I further understand that is my child's responsibility to report any changes in their income or health insurance coverage to KTYHC before each visit.
I authorize the clinic to bill insurance, Medicaid or another 3rd party payer, if applicable. If the services are not paid by the third party payer, I understand I may get a bill in the mail for a discounted rate. If there is no 3rd party payer to bill, I understand payment is due at the time of each visit. I may be billed at a discounted rate if my son/daughter is unable to cover the amount due at the time of service. I understand my son/daughter will not be denied services, and unpaid balances will not be sent to collections, due to inability to pay.

I understand that I may call to talk with the provider about my child's health care at anytime; however, any information regarding confidential services to minors protected by Michigan Law will be excluded, unless there is a release on file allowing the provider to share this information.

SIGNATURE OF PARENT /GUARDIAN: _____ DATE:_____
REVIEW BY CLINIC STAFF: _____ DATE:_____

Clinic Use Only:
Parent/Guardian has revoked consent for:☐ All Services ☐Vaccines Only, specify _____
☐Other, specify _____ on (date)_____ at (time) _____.
Clinic Staff Signature: _____ Date: _____