Youth Health & Wellness Center

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Health Department GRAND TRAVERSE COUNTY

Adult Consent for Services

Pt # _____

(For patients over 18 thru 21 years old)

Patient's Name	Date of Birth	Male □ Female □	Preferred Pronouns:	
Address	City	Zip Code	County	Home Telephone #
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

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

Policy #	**Group #**	
Member Name:		Birth Date:

Your Cell phone # _____ Can we text you at this number? □ Yes □ No

Do you attend school: _____ No _____ Yes If yes, where? _____

Name of your Primary Care Provider _____

Date of your last visit _____ Reason for last visit: _____

Date of your last Annual Exam or Comprehensive Physical _____

SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER

Services at Youth Health & Wellness 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
- Sexually transmitted infection testing, treatment and counseling
- HIV education, counseling, testing and referral

NO BIRTH CONTROL PILL OR DEVICES ARE DISPENSED OR PRESCRIBED AT YOUTH HEALTH & WELLNESS

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

I give my consent to receive all provided services listed above at Youth Health and Wellness Center. I understand that I may withdraw my consent for services upon written notice to Youth Health and Wellness Center.

I authorize the Youth Health and Wellness Center to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the Youth Health and Wellness Center and my primary care physician to release information to each other for the purpose of continuity and coordination of care. I also 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 I receive services at both clinics. 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 I may have the opportunity to participate in educational programs related to health and wellness topics, as well as can give feedback on services and programs through questionnaires or focus groups.

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

I understand I may be administered a behavioral risk assessment during my appointment at YHWC.

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 Youth Health and Wellness Center.

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 responsibility to report any changes in my income or health insurance coverage to Youth Health and Wellness Center 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 I unable to cover the amount due at the time of service. I understand I will not be denied services, and unpaid balances will not be sent to collections, due to inability to pay.

SIGNATURE OF PATIENT: _____ DATE:_____
REVIEW BY CLINIC STAFF: _____ DATE: _____

Clinic Use Only:

Patient has revoked consent for: ☐ All Services ☐ Vaccines Only, specify _____

☐ Other, specify _____ on (date)_____ at (time) _____.

Clinic Staff Signature: _____ Date: _____