Grand Traverse County Health Department E3 at Traverse City Area Public Schools (TCAPS)

Parent Consent for Services

(For clients less than 18 years old)

Pt #: _____

Client Name:		Date of Birth:	
Address:	City:	Zip Code:	County:
Parent/Guardian:	Relationship to Client:	Work Ph #:	Cell Ph #:
Does Student live with Parent(s)? ☐ Yes ☐ No If no, where? _____			
Emergency Contact:	Relationship to Client:	Work Ph #:	Cell Ph #:

Client Phone #: _____ May we call you? ☐ Yes ☐ No May we text you? ☐ Yes ☐ No	Client Email: _____ May we contact you via email? ☐ Yes ☐ No
Race: (Please check one or more) ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan ☐ Hawaiian/Pacific Islander	Ethnicity: (Please check if applicable) ☐ Hispanic ☐ Arabic ☐ Non-Hispanic ☐ Non-Arabic
Insurance: ☐ No Insurance ☐ Medicaid ☐ BCBS ☐ Priority Health ☐ Other:_____	
Policy #:	Group #:
Subscriber Name:	Subscriber Date of Birth:
CURRENT MEDICATIONS: _____ ALLERGIES: _____	

Michigan Law allows a minor under the age of 18 to seek some medical services without notification or approval of their parent/guardian. At this clinic a minor may seek only the following services without permission from a parent or guardian:

- Substance abuse counseling and treatment (between ages 14-18).
- Mental health counseling (between ages 14-18).

Services by Grand Traverse County Health Department E3 sites in TCAPS:

- Available without regard to patient's sex, race, religion, gender identity, or sexual orientation
- Health Risk Assessment
- Mental Health Services
- Crisis Intervention
- Referrals to Community-Based Services

By signing below, I am giving my consent for the above-named student to receive all provided services listed above by Grand Traverse County Health Department (GTCHD) E3 at Traverse City Area Public Schools (TCAPS). Further, I certify that I am the legal guardian, parent, or representative of the student named above. I understand that I may withdraw my consent for a specific service and/or all services at any time by notifying a GTCHD E3 at TCAPS staff member verbally or in writing. If I verbally make such a request, a written notice may also be requested of me for confirmation.

- I authorize the GTCHD E3 at TCAPS to release information regarding treatment to insurance or others for the purpose of receiving payment for services. I further authorize the GTCHD E3 at TCAPS and my child's primary care physician to release information to each other for the purpose of continuity and coordination of care.

- I authorize the GTCHD E3 at TCAPS to release information regarding appointments to my child's school when needed to coordinate services at school. A separate release of information is needed to disclose information beyond appointment time and status with school authorities.

- 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 feedback on services and programs through questionnaires, surveys, or focus groups.

- I understand that my/my child's privacy is of the utmost importance to the GTCHD E3 at TCAPS staff and that health information is always handled in a confidential manner as required by law.

- I understand that my child may be administered a behavioral risk assessment during their appointment.

- I understand that I have a right to receive a written copy of the Grand Traverse County Health Department *Notice of Privacy Practices* upon request.

- I understand that it is my/my child's responsibility to report any changes in their health insurance coverage to the GTCHD E3 at TCAPS before each visit.

- I authorize the clinic to bill insurance, if applicable. I understand that my child will not be denied services if they do not have insurance.

- I understand that I may call to talk with the provider about my child's health care at any time; 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 CLIENT: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

SIGNATURE OF CLINIC STAFF: _____ DATE: _____