



880 Parsons Rd., Traverse City, MI 49686 Ph: 922-6416 Fax: 922-6472  
 Email address: [yhwc@qtchd.org](mailto:yhwc@qtchd.org) Website: [www.qtchd.org](http://www.qtchd.org)

## Registration / Billing Information

Pt # \_\_\_\_\_

(For patients less than 18 years old)

|   |  |                          |  |  |                   |
|---|--|--------------------------|--|--|-------------------|
| Patient's Name  |  | Date of Birth            | Male <input type="checkbox"/><br>Female <input type="checkbox"/>   | 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 #        |
| <b>Race: (Please check one or more)</b><br><input type="checkbox"/> Am Indian/Alaskan <input type="checkbox"/> Black/African American<br><input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian<br><input type="checkbox"/> Native Hawaiian/Pacific Islander |  |                          | <b>Ethnicity: (Please check one or more)</b><br><input type="checkbox"/> Arabic <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Non-Arabic <input type="checkbox"/> Non-Hispanic |  |                   |
| <b>Insurance:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS <input type="checkbox"/> Priority Health <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Insurance  |  |                          |  |  |                   |
| <b>Policy #</b>   |  | <b>Group #</b>           |  | <b>Immunization Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Prescription Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Laboratory Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |
| Member Name:  |  |                          | Birth Date:  |  |                   |

Patient Cell # \_\_\_\_\_

Patient attends:   \_\_\_ CTC   \_\_\_ TC High   Other: \_\_\_\_\_   \_\_\_ Not in school

Name of Primary Care Provider \_\_\_\_\_ Primary Care Phone # \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason for last visit: \_\_\_\_\_

Date of last Well Child Exam or Comprehensive Physical \_\_\_\_\_

### SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER (YHWC)

**Services at Youth Health & Wellness 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.**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Physical exams (including comprehensive, school, sports, work, camp) which may include vision &amp; hearing tests, basic lab tests, spirometry, etc.</li> <li>• Treatment for acute &amp; chronic illness &amp; injuries</li> </ul> | <ul style="list-style-type: none"> <li>• Prescription and over-the-counter medications</li> <li>• Administration of immunizations (as recommended by ACIP) and TB skin testing</li> <li>• Referrals for specialty services</li> <li>• Annual health risk assessment</li> </ul> | <ul style="list-style-type: none"> <li>* Crisis intervention</li> <li>* Substance abuse education, counseling</li> <li>* Mental Health services</li> <li>* Pregnancy testing and referrals</li> <li>* Sexually transmitted infection testing, treatment and counseling</li> <li>* HIV education, counseling, testing and referral</li> </ul> |
|--|--|--|

*\*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.*

**NO birth control pills or devices are dispensed or prescribed at Youth Health and Wellness Center.**

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 Youth Health and Wellness 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 YHWC 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 YHWC to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the YHWC 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 Care (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 YHWC 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 YHWC 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 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 YHWC.

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 YHWC 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.

|   |                    |
|---|--------------------|
| <b>SIGNATURE OF PARENT /GUARDIAN:</b> _____ | <b>DATE:</b> _____ |
| <b>REVIEW BY CLINIC STAFF:</b> _____        | <b>DATE:</b> _____ |

**Clinic Use Only:**

Parent/Guardian has revoked consent for:  All Services  Vaccines Only, specify \_\_\_\_\_

Other, specify \_\_\_\_\_ on (date) \_\_\_\_\_ at (time) \_\_\_\_\_.

Clinic Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_