Beaumont Teen Health Center - Romulus
9650 S. Wayne Rd., Romulus, MI 48174
734-942-4857 FAX 734-942-6734

Child Information and Parent Acknowledgement Consent and Authorization Form

Child's Name_____ ☐ Male ☐ Female Date_____
Parent's Name_____
Child's Date of Birth_____ Age_____ School_____
Race: White Black Multi-racial **Ethnicity:** Hispanic Non-Hispanic
American Indian Asian/Pacific Islander Unknown Arabic Non-Arabic Other

Grade_____ **School**_____ **Cell Phone Number** _____/**Home Phone** _____

_____ _____ _____ _____
Home Address **City** **Zip** **Emergency Contact Name/Relation, Phone #**

Name of current Medication(s) _____ For (condition)_____
Has your child ever been hospitalized overnight Yes No
If yes, Why?_____ Date of hospitalization_____
Family Doctor Name_____ Phone number_____

Medical Information - Does your child have any of the following? Please Circle YES or NO

Allergies Yes No To what _____	Medication Allergy? Yes No To What_____	Food Allergy? Yes No To What_____ Epi-pen at school? Yes No
ADHD/Mental Health Yes No	High Blood Pressure Yes No	Seizures Yes No
Asthma Yes No	Kidney Problems Yes No	Sickle Cell Yes No
Diabetes Yes No	Overweight Yes No	Stomach Problems Yes No
Heart Problems Yes No	Headaches/Migranes Yes No	Other? Yes No

Family History (M=Mother F=Father S/B=Sister/Brother GP=Grandparent A/U=Aunt/Uncle)

	None	M	F	S/B	GP	A/U		None	M	F	S/B	GP
Allergies							Heart Attack/Stroke/ Sudden Death before age 55					
Asthma							High Blood Pressure					
Bleeding disorders/sickle cell							Heart Attack/Stroke after age 55					
Cancer							High cholesterol					
Depression/Mental Health Problems							Kidney Disease					
Diabetes							Seizures					
Eating Disorders							Substance abuse (alcohol or drugs)					
Other							Smoking					

Insurance: Name_____ Numbers_____
Subscribers: Name_____ Subscriber's date of birth_____
Medicaid/MI-Child Plan _____ ID Number_____
☐ I do not have medical insurance
☐ Check here if you want us to call you for help getting insurance. Please call 734-942-4857 or stop by the clinic if you would like to get a Medicaid application or to make an appointment.

Patients are entitled to receive safe effective, adequate and appropriate care regardless of their race, religion, creed, color, national origin, sex, age disability handicap, marital status, sexual orientation or ability to pay.

Referred by: _____ **Turn Over for Consent**

Oakwood

Westwood Teen Health Center
25912 Annapolis St
Inkster, MI 48141
313.565.2174

River Rouge Teen Health Center
1460 W. Coolidge Hwy
River Rouge, MI 48218
313.843.1639

Taylor Teen Health Center
26650 Eureka Road
Suite B
Taylor, MI 48180
734.942.2273

Romulus Teen Health Center
9650 Wayne Rd
Romulus, MI 48174
734.942.4857

CONSENT

NAME:

MR #:

BIRTHDATE:

PATIENT/PARENT CONSENT TO TREATMENT

Patient Name:_____ Birth Date:_____

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SECTION 1

The Oakwood Teen Health Centers provide a wide range of medical care, metal health care and health education services to adolescents and young adults, including: physicals, immunizations, sick care, first aid, lab tests and prescriptions, skin and nutrition care- hearing and vision screening, sexually transmitted infection diagnosis and treatment, HIV counseling and testing, reproductive health education and referral, individual and group counseling and referral and substance abuse prevention, assessment and referral. Services are rendered without regard to Sex, race, religion or sexual orientation.

The Oakwood Teen Health Centers measure the patient's height and weight and record that information in the Michigan Care Improvement Registry's (MCIR) Body Mass Index (BMI) Growth Module. Oakwood Teen Health Centers use the resources and tools in the module to promote healthy weight and lifestyle habits for our patients. Use of the module is optional and you may choose to decline this service. Let us know if you decline.

I consent to allow the Oakwood Teen Health Centers to provide treatment, including but not limited to the services listed above, as the physician and health care staff of the Teen Health Center consider necessary I understand that I can withdraw my consent at any time by giving notice in writing. If I am signing as a parent/guardian, this consent is valid until the patient turns age 18.

I understand that Michigan law does not require a parent to consent for a minor to receive advice or treatment of drug abuse, alcoholism, sexually transmitted diseases, including HIV, reproductive health care, or outpatient counseling. At the health providers discretion, a parent may be notified if the situation is dangerous or life threatening.

I understand that testing for blood borne diseases, including HIV, may be performed without a separate written consent if a health professional, volunteer, student or employee of Oakwood is exposed to the patient's blood or body fluids through skin, mucous membrane, or open wound.

SECTION 2

Immunizations and Vaccinations - I understand my child's immunization (shot) records from the schools and the Michigan Care Improvement Registry will be reviewed **If it is determined that my child needs a required shot, I give my permission for it to be given at the Oakwood Teen Health Center.** I understand a letter with the needed shot and a vaccine Information Sheet will be sent home for my review at least 1 week before the immunization is planned, or given to me at the clinic the day the immunization is given. The required shots include DTap/DT/TD/Tdap, Hepatitis B, IPV (polio), Meningococcal (Meningitis), Measles, Mumps, and Rubella (MMR), and Varicella (Chicken Pox). The recommended shots include: Hepatitis A HPV(gardasil) and Influenza (flu). If I agree, I understand that at any time I no longer want my child to be immunized, I can contact the clinic and withdraw, the consent.

☐ **Yes, I agree** ☐ **No, I do not agree. Please initial**_____

SECTION 3

Authorization to Pay Insurance Benefits to the Oakwood Teen Health Centers and Release of Information
I authorize my insurance carrier to pay the Oakwood Teen Health Centers for services rendered to me/my child that are covered under my health insurance plan. I understand I may be responsible for fees and charges if my health care provider does not participate in my health insurance plan. I also understand I may be responsible for fees and charges that are co-pays, deductibles, or that are for services that are not covered under my health insurance plan. I also authorize the Oakwood Teen Health Centers to release medical information to any Oakwood Healthcare System hospital, facility, entity or physician, or me/my child's primary health care provider for continuity of care. A copy of this authorization may be used in place of the original. I understand that I or my insurance carrier may withdraw this authorization at any time by giving notice in writing. I also understand that the facility will protect the information in my medical record, but than from time to time the facility must release information regarding the care provided to state or federal regulators. I understand that if a test for certain sexually transmitted infections is positive, the law requires the reporting of the positive result to a public health agency.

I consent for treatment as stated in above Sections 1 2 and 3.

Signature of Parent / Guardian **Date**

_____ _____

Patient **Date**

_____ _____

Parental consent to withdraw care or treatment from the Oakwood Teen Health Centers.
☐ **Medical** ☐ **Mental Health**

Signature of Parent / Guardian **Date**

_____ _____

Oakwood

HIPAA

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Oakwood Healthcare Notice of Privacy Practices. I understand this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

Signature of Patient or Representative _____ Date/Time _____

Relationship to Patient _____

Printed or Typed Name _____

Witness or Signature of Oakwood Employee _____ Date/Time _____

If the patient does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

- ☐ Patient given a copy of the Notice but refused to sign form.
- ☐ Patient unable to sign related to:
  - ☐ Emergency treatment situation
  - ☐ Unconscious
  - ☐ Mentally Incompetent
  - ☐ Language Barrier
  - ☐ Other (explain): _____

Signature of Oakwood Employee _____ Date/Time _____

Oakwood®

CONSENT

RX HISTORY CONSENT

Permission to Communicate my Health Information Electronically

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature _____ Date _____

Parent Signature _____ Date _____