Tiger Health Extension
School-Based Health Center
Patient Consent to Treatment Packet

Thank you for enrolling your child in the school-based health center program! One consent packet is needed for each child. Please print (or type) the information needed below. Please complete the ENTIRE packet of information.

To sign these documents, you must be the legal parent or guardian of the minor child.
Individuals 18 years or older must sign for themselves.

If you need assistance completing this form, please contact the school-based health center.

Patient Full Name	Date of Birth	Age	Gender	Grade	School

Primary Address	City	Zip Code	(Patient) Cell Phone #

Ethnicity (Please check)

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (Please check)

☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ White
☐ Other Pacific Islander ☐ More than one race
☐ Black African American ☐ Other_____

Language best served in:

☐ English ☐ Other: _____

Please describe any special accommodations you require: _____

_____

☐ **Check here if you are a legal adult (18 years of age or older) and completing this form for yourself.**

Custodial Parent/Guardian: Last Name	First Name	Date of Birth	Relationship

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other_____	Cell Phone #	Work Phone #

Parent/Guardian: Last Name	First Name	Date of Birth	Relationship

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other_____	Cell Phone #	Work Phone #

Patient lives with:	**Please list any special child custody arrangements below:**	**Patient bill goes to:**

Emergency Contact 1: Last Name	First Name	Phone #	Relationship

Emergency Contact 2: Last Name	First Name	Phone #	Relationship

Patient Name:	Patient DOB:

School-Based Health Center Health Insurance Information

Tiger Health Extension participates with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. If you are uninsured, or have private insurance please be sure to complete the sliding fee scale in this packet as you may qualify for reduced co-pay rates. Our SBHC team can also assist uninsured families with Medicaid enrollment. Please check the box below if you would like further assistance.

Primary Insurance:	Subscriber Name:	Subscriber/Policy Number:	Group #:
	Subscribe Address:	Subscriber Birthdate:	
Secondary Insurance:	Subscriber Name:	Subscriber/Policy Number:	Group #:
	Subscribe Address:	Subscriber Birthdate:	

Would you like assistance enrolling in health insurance (Medicaid)? ☐ Yes ☐ No

Patient's Current Service Providers

Please list all of your child's service provider information below. The school-based health center and the providers listed below will exchange health care information, including sensitive information, for the purpose of coordination of care for your child. Information exchange will not occur without your knowledge.
Please see page 7 of this consent packet for further details.

Patient's Primary Health Care Provider:	**Primary Health Care Provider's Telephone Number:**
Patient's Pharmacy:	**Pharmacy Address:**
Patient's Behavioral Health Provider:	**Behavioral Health Provider's Telephone Number:**
Additional Provider(s): (eg: specialist, case manager, eye doctor, etc)	**Telephone Number:**

Family Income Information

As a requirement of the federal funding our health center receives, we are required to report income and family size. Your response to this is confidential. Information reported will be aggregated and reported collectively. Individual information is not reported.

Head of household: (Name)	Head of Household Date of Birth:	Number of individuals in the household:

CHECK THE BOX next to the range that best describes your family annual income:

☐ (0-$25,000) ☐ ($25,000-$50,000) ☐ ($50,000-$75,000) ☐ ($75,000-$100,000) ☐ (Over $100,000)

Are you homeless? ☐ Yes ☐ No

If yes, please check the box that applies:

☐ Shelter ☐ Transitional Housing
☐ Street ☐ Doubled Up
☐ Unknown (homeless/none of the above)
☐ Other (hotels, day-to-day housing

Agricultural Status: ☐ Not agricultural worker
☐ Migrant worker ☐ Seasonal worker

Would you like to be connected with a Community Health Worker to help with any resources you may need? ☐ Yes ☐ No

Patient Name:	Patient DOB:

School-Based Health Center Patient Medical History:

Date of Last Well Child Exam:	Date of Last Dental Cleaning:

Please list ALL the current medications your child takes, along with the dose and frequency of the medication. If you need additional space, please attach a separate document listing the additional medications to this form.

Medication	Dose	Frequency	Medication	Dose	Frequency

Please check "Yes" or "No" for each item listed below:	
Any allergies to medications? **If yes, please list medication and reaction**:	☐ Yes ☐ No
Any history of severe allergic reaction or anaphylaxis?	☐ Yes ☐ No
Any food allergies? **If yes, please list:**	☐ Yes ☐ No
Any surgeries (eg: tonsils, hernia, appendix) **If yes, please list type of surgery & year:**	☐ Yes ☐ No
Any serious injuries? (**please list type & year)**	☐ Yes ☐ No
Has your child ever been hospitalized overnight for a reason not mentioned above? **If yes, please list reason & year:**	☐ Yes ☐ No
Any mental health history (eg: depression, anxiety, eating disorder, etc)?	☐ Yes ☐ No

Does your child have any of the conditions listed below?	
ADD/ADHD	☐ Yes ☐ No
Allergies/Hay Fever/Sinus Problems	☐ Yes ☐ No
Anemia (low iron/blood count)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Autism	☐ Yes ☐ No
Bladder Problems (bed wetting)	☐ Yes ☐ No
Blood Disorder/sickle cell anemia	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Celiacs Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Fainting/Concussions	☐ Yes ☐ No
Headaches/migraines	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Hypertension (high blood pressure)	☐ Yes ☐ No
Mononucleosis (Mono)	☐ Yes ☐ No
Scoliosis	☐ Yes ☐ No
Seizures/Epilepsy	☐ Yes ☐ No
Severe Acne	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No
Any other problems not listed, please list below:	☐ Yes ☐ No

Please place a check below each medical condition and the family member who has the disease

	Mental Health	Asthma	Cancer	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Seizures	Sickle Cell	Thyroid Disease
Mother										
Father										
Sibling(s)										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Other (please describe)										

Patient Name:	Patient DOB:

School-Based Health Center Consent for Vaccinations:

Please complete the information below to let our SBHC staff know if you'd like your child to receive vaccinations at the school-based health center. A staff member will call you to schedule your child's vaccinations before they administer them. We recommend that you join your child for all vaccination appointments.

The School-Based Health Center, along with the Centers for Disease Control (CDC) advises you that your child should receive the following vaccinations:

Hepatitis A (HepA); Hepatitis B (HepB); Diptheria, Pertussis & Tetanus (DTaP), Tetanus, Diphtheria, Acellular Pertussis (TdaP); PCV15, PCV20 (Pneumococcal Disease) Measles, Mumps, Rubella (MMR); Varicella (Chickenpox); Meningococcal (Meningitis); Meningococcal B (Men B); Polio (IPV); Gardasil (HPV);

Vaccine information sheets MUST be viewed prior to receiving vaccinations at the link below or by scanning the QR code:
https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/immunizations/michiganvis

(please see the attached form on the next page for immunizations required for school entry in the State of Michigan)

(Please SIGN ONE option below)	Vaccination Consent:
	I give consent to have my child receive **all** the recommended vaccinations (listed above) at the School-Based Health Center
	I **give consent** for my child to receive **all** the recommended vaccinations (listed above) at the School-Based Health Center **EXCEPT** the following: **(Please list below any vaccinations you do NOT want your child to receive)**
	I DO NOT give consent for my child to be vaccinated at the School-Based Health Center.

I understand that the purpose of the recommended vaccination is to prevent the communicable diseases that once killed or harmed infants, children, and adults. Unvaccinated people are at risk of contracting these preventable diseases and passing them to others. Contracting vaccine preventable diseases results in the loss of school and work time, and may result in the cost of doctor appointments, hospitalizations, or premature death. I also understand that any vaccines administered are recorded in the Michigan Immunization Registry.

Patient/Parent/Guardian Name (Printed)	**Patient/Parent/Guardian Signature**	**Date**

Please initial ONE:	If you have chosen to allow your child to receive vaccinations at the SBHC, please select ONE of the options below. Please note, that parents will be contacted by the school-based health center staff BEFORE vaccinations are given.
	I would like to be present for my child to receive vaccinations at the school-based health center.
	My child can receive vaccinations at the school-based health center without a parent/guardian present.

Vaccines Required for School Entry in Michigan

Whenever children are in group settings there is a chance for disease to spread. Children must follow vaccine laws in order to attend school. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect children from serious diseases is to follow the recommended vaccination schedule at cdc.gov/vaccines. When following the recommended schedule children are fully protected and any school vaccination requirements are met.



	All Kindergarteners and 4-6 year old transfer students	All 7th Graders and 7-18 year old transfer students
Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)	4 doses DTP or DTaP 1 dose must be at or after 4 years of age	4 doses diphtheria and tetanus or 3 doses if 1st dose given on or after 1 year of age 1 dose Tdap at 11 years of age or older upon entry into 7th grade or higher
Polio	4 doses or 3 doses if dose 3 was given on at or after 4 years of age	
Measles, Mumps, Rubella (MMR)*	2 doses at or after 12 months of age	
Hepatitis B*	3 doses	
Meningococcal Conjugate (MenACWY)	None	1 dose at 11 years of age or older upon entry into 7th grade or higher
Varicella (Chickenpox)*	2 doses at or after 12 months of age or Current lab immunity or History of varicella disease	

***If the child has not received these vaccines, documented immunity is required.** All doses of vaccines must be valid (correct spacing and ages) for school entry purposes. These rules apply to children who are the above ages upon entry into school. During disease outbreaks, incompletely vaccinated children may be excluded from school. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at Michigan.gov/Immunize.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHHS-Pub-1378 (Rev. 6-21)

MDHHS
Michigan Department of Health & Human Services

Patient Name:	Patient DOB:

Tiger Health Extension Patient Portal Enrollment:

Tiger Health Extension offers all patients access to their patient chart through an online patient portal.
Would you like to sign up for the patient portal for your child or yourself (if 18 or older)? ☐ Yes ☐ No
If yes, please provide your email address:

Patient Name:	**Patient DOB:**

By signing this form, I acknowledge the following in regard to the School-Based Health Center:

Consent for Treatment: I consent to routine diagnostic procedures, including but not limited to physical exams (well child, sports, school, & camp), immunizations (unless opted out on previous form), blood draw, laboratory tests, treatment for acute illness and injuries, student health assessment, education and risk counseling and testing, and administration of medication and to medical treatment rendered by physicians and staff of Tiger Health Extension and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating provider.
I understand that no contraceptives may be prescribed or dispensed on school property. I understand that abortion counseling, referrals, or services cannot be provided at the school-based health center.

Sharing Health Information: Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency may use and share most of your health information to provide you with treatment, receive payment for your care, and manage/coordinate your care. However, your consent is required to share certain types of health information with other people you may wish to have involved in your health care. **I authorize both the school-based health center and my child's primary care physician, mental health provider and/or specialist to exchange health care information, including sensitive information for the purpose of coordination of care for my child.** I agree to allow conversation about my child with school staff when academic success is related to a health issue. I give permission for the health center staff to access my child's school attendance and schedule. I understand that in certain circumstances the school-based health center may also need to exchange information on my child with the school administration. Circumstances in which this would occur include medical or mental health emergency situations or information regarding communicable diseases that would be easily contagious to other students or life-threatening situations to the patient.

Referrals: I give permission for my child to be referred by the Tiger Health Extension provider to a specialist, as needed. I understand I will be contacted prior to the referral being made.

Behavioral Health Services: I acknowledge that behavioral health services are available upon request. These services include but are not limited to, individual counseling, family counseling, substance abuse counseling & referral, physical and sexual abuse counseling & referral. I understand that all healthcare information is confidential. Confidentiality between the Patient, parent/guardian and the therapist is assured. By law, some information requires the patient's signed consent prior to disclosure to anyone, including parents/guardians. The SBHC staff will encourage every patient to involve his/her parent/guardian in health care decisions.

Authorization for Payment Agreement: Tiger Health Extension participates with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. I authorize any insurance benefits to be paid directly to Tiger Health Extension realizing I am responsible to pay non-covered services. I understand that if I have private insurance or am uninsured, I can apply for the Tiger Health Extension sliding payment scale (included on pages 12-13 of this packet).

Privacy Practices Notice: I acknowledge being offered a copy of the Tiger Health Extension Notice of Privacy Practices which is available at Notice-of-Privacy-Practices.pdf or by request.

By signing this form, I certify that I am the legal guardian and/or legal custodian of the patient named above. I give consent for my child to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I understand that I may withdraw my consent for services upon written notice to Tiger Health Extension.

I have reviewed, understand and consent to the services offered, and agree to allow my child to be seen by themselves at the school-based health center.

Patient's Name: _____

Patient/Parent/Guardian Printed Name: _____

Patient Name:	**Patient DOB:**

Patient/Parent/Guardian Signature:

_____

Date: _____

Michigan law mandates confidential services to minors without the consent or knowledge of a parent/guardian. Confidential services include advice, testing and/or treatment for drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services. These confidential services are available for minors 12 years of age or older. Additionally, a minor 14 years of age or older can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. People who are age 18 or older, legally emancipated, legally married, under court-order, in the presence of a law officer when the parent cannot be promptly located, and/or members of the US Armed Forces provide consent for services themse iden tity, or the ability to pay. **No birth control pills or , or services are provided.**

Crisis intervention and emergency care do not require parental consent.

School-Based Health Center
Delegation of Treatment Form

Delegation of Consent for Treatment of Your Child: You may appoint individuals over the age of 18 of age to authorize treatment in your absence. I, being the parent or legal guardian of the above-named minor, do hereby appoint the following individual(s) to act on my behalf in authorizing medical, surgical, care, and hospitalization for my minor child. In no event shall this delegation of parental rights be effective for more than 12 months.

Contact Name: _____ Relationship: _____ Phone Number: _____

Contact Name: _____ Relationship: _____ Phone Number: _____

Contact Name: _____ Relationship: _____ Phone Number: _____

Contact Name: _____ Relationship: _____ Phone Number: _____

Contact Name: _____ Relationship: _____ Phone Number: _____

Contact Name: _____ Relationship: _____ Phone Number: _____

Patient's Name: _____

Patient/Parent/Guardian Printed Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Patient Name:	Patient DOB:

SCHOOL-BASED HEALTH CENTER
TIGER HEALTH EXTENSION
AUTHORIZATION FOR TREATMENT

Tiger Health Extension provides integrated primary medical, mental health, dental care, and other health care services to meet your needs regardless of age, gender, gender identity, color, race, ethnicity, creed, national origin, religion, disability, sexual orientation, or veteran status. The purpose of that care is:

- To obtain information through a history and examination for diagnosing and developing a plan of treatment
- To treat disease, mental health, injury, and disability by testing, use of procedures, therapies, and medications
- To aid patients in achieving their maximum potential within their capabilities
- To accelerate patient's gradual return to health and strength after illness and reduce the length of the functional recovery.

At Tiger Health Extension all providers work as a team. As part of your integrated care, we use an electronic health record that includes your medical, mental health, dental, and other health information. To give you the best care possible, all of your care team will view that complete record. This authorization also pertains to the Federal Regulation 42 CFR Part 2 of the State Statutes regarding Mental Health, Alcohol, and Drug Abuse. It also pertains to any record of testing, care, prescription, reports, or research pertaining to infection with HIV or Acquired Immunodeficiency Syndrome (AIDS) including records otherwise protected under Act 488, Public Acts of Michigan (1988).

I, the undersigned,

1. Voluntarily consent to integrated treatment (including emergency care) considered necessary by today's standards for the patient whose name appears above; understand that the treatment and procedures will be performed by providers and/or employees of Tiger Health Extension; acknowledge that I have read the above and understand its contents.

2. Understand that if my treatment and care are terminated either by me or my Primary Care Provider (PCP) for any reason, any and all services I receive from any AHC provider may be terminated.

3. I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tiger Health Extension all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Tiger Health Extension to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

4. Agree to full cooperation and participation in all treatment provided as defined in the plan of care as established.

5. Understand that I have the right, subject to certain conditions, to:

    a. Request restrictions on certain uses and disclosures of facts about me upon request. However, Tiger Health Extension is not required to agree to the requested restrictions.

    b. Receive confidential communication of protected health data by giving Tiger Health Extension another address or means of receiving health data.

    c. Inspect and copy protected health data by filling out health records request form (unless the contents are deemed dangerous to the patient or others).

    d. Attach or affix protected health data on request.

    e. Receive a list of releases made about my protected health data upon request.

    f. Obtain a paper copy of this form upon request, if you agreed to receive this form by E-mail, fax, or website.

Patient/Guardian Signature: _____Current Date:_____

Witness Signature: _____ Current Date:_____

Patient Name:	Patient DOB:

SCHOOL-BASED HEALTH CENTER
TIGER HEALTH EXTENSION
ALTERNATIVE MEANS OF COMMUNICATION/PATIENT RECORD OF DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home telephone _____

- ☐ Okay to leave message with detailed information.
- ☐ Leave message with call-back number only.

☐ Work telephone _____

- ☐ Okay to leave message with detailed information.
- ☐ Leave message with call-back number only.

☐ Written communication.

- ☐ Okay to mail to my home address.
- ☐ Okay to mail to my work/office address.
- ☐ Okay to fax to this number _____

☐ Other: (Persons that have permission to receive information about my child.)
The following people have my permission to receive protected health information about my child:

Name	Relationship to Patient	Phone #:

☐ Other: Any other type of communication not listed above. _____

_____

*Unless you provide verbal or written declination, an automated calling program may be used to deliver appointment reminders/messages to your home, work, and/or cellular telephone.

_____ _____
Patient/Parent Signature Date

_____ _____
Print Patient Name Birth Date

School-Based Health Center
TIGER HEALTH EXTENSION

PATIENT ACKNOWLEDGEMENT FORM

Effective April 14, 2003, the new Federal Law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; and identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another physician/dentist or other health professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Patient/Parent or Guardian Signature Patient Name (Please Print) Date

_____

Date of Birth

SCHOOL-BASED HEALTH CENTER
TIGER HEALTH EXTENSION
SLIDING PAYMENT SCALE

Tiger Health Extension offers our patients a SLIDING PAYMENT SCALE for patient fees. The scale is determined by family size and income. Funding for the Sliding Payment Scale is made available through a grant from the Department of Health and Human Services. Alcona Health Center patient can apply for the Sliding Payment Scale program, including individuals who have health insurance.

If you would like more information on how to enroll in the AHC Sliding Payment Scale Program, please place your information below, and a member of our SBHC staff will contact you to get started.

_____ _____

Name Phone Number

SCHOOL-BASED HEALTH CENTER
TIGER HEALTH EXTENSION
SLIDING PAYMENT SCALE REFUSAL WAIVER
(for patients who do not want to apply for Sliding Fee Discounts)

☐ **I have been given the opportunity to apply for Alcona Health Center's sliding fee discount program, and I do not wish to apply for the AHC sliding fee discount program at this time.**

Because you do not wish to apply or comply with the requirements to apply for the AHC sliding fee discount program, you are choosing to be a self-pay patient. This means that you will pay your deductible and/or service fees at the time of service. You will be responsible for any and all balances due after the charges for your visit are entered.

Patient/Parent or Guardian Signature _____ **Date** _____