Youth Health & Wellness Center

880 Parsons Rd., Traverse City, MI 49686 Ph: 922-6416 Fax: 922-6472
Email address: yhwc@gtchd.org Website: www.gtchd.org

(For clients age 18 & over)

Registration / Billing Information

Pt # _____

Client Name	Birth Date	Age	Male □ Female □	School	Grade

Address	City	Zip Code	County	Home Telephone #

Parent/Guardian:	Relationship:	Parent Work Phone #	Parent Cellular #

Name of Emergency Contact	Relationship	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

Are you employed? □Yes □ No Where? _____ Weekly hours: _____ Hourly rate:_____

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

Policy #	**Group #**	**Immunization Coverage? □ Yes □ No** **Prescription Coverage? □ Yes □ No** **Laboratory Coverage? □ Yes □ No** **Office co-pay? _____**

Member Name:	Birth Date:

Do you live with your parents? □ Yes □ No If no, where? _____

Your Cell # _____ Can we text you? □ Yes □ No

Your email address _____ Can we email you? □ Yes □ No

Do you attend: ____ CTC ____ TC High Other School: _____

Name of Health Care Provider _____

Date of last visit _____

□ Please send a visit summary to my Primary Care Physician as needed.

Youth Health & Wellness Center Consent for Services

IMMUNIZATIONS

Immunization status will be verified at every visit.

I give Youth Health & Wellness Center authorization to obtain a copy of my immunization record from the school's office, primary care provider's office, or the County Health Department. I authorize Youth Health & Wellness Center to enter my immunizations into MCIR (Michigan Care Improvement Registry). _____ (Patient Initials)

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

SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER (YHWC)

- 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

* Crisis intervention
* Substance abuse education, counseling
* Mental Health and psycho-social assessment, counseling, treatment and referrals
* Pregnacy testing and referrals
* Sexually transmitted infection testing, treatment and counseling
* HIV education, counseling, testing and referral

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

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

I authorize the Youth Health & 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 & 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 Care (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 have the opportunity to 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 that 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 Youth Health & Wellness Center *Notice of Privacy Practices* which is available at Youth Health & 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 it is my responsibility to report any changes in my income or health insurance coverage to Youth Health & 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 CLIENT:_____ **DATE:**_____

REVIEWED BY: _____ **DATE:** _____

Updated 8/8/2014