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

Registration/Billing Information

Pt # _____

(For patients age 18 years and older)

Patient's Name	Date of Birth	Male □ Female □	Preferred Pronouns:	
Address	City	Zip Code	County	Home Telephone #
Name of Emergency Contact	Relationship to Patient:	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

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

Policy #	**Group #**	**Immunization Coverage? □ Yes □ No** **Prescription Coverage? □ Yes □ No** **Laboratory Coverage? □ Yes □ No**
Member Name:		Birth Date:

Your Cell phone # _____

Do you attend school: _____ No _____ Yes If yes, where? _____

Name of your Primary Care Provider _____Primary Care Phone:_____

Date of your last visit _____ Reason for last visit: _____

Date of your last Annual Exam or Comprehensive Physical _____

SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER (YHWC)

Services at Youth Health & Wellness Center 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.

- 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
- Annual health risk assessment
- Crisis intervention
- Substance abuse education, counseling
- Mental Health services
- Pregnancy 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.

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

I give my consent to receive all provided services listed above at Youth Health & Wellness Center. I understand that it is my responsibility to seek medical attention or call the YHWC if I have continued problems. I have the right to refuse or defer treatment unless I intend to harm myself or someone else.

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 Grand Traverse County Health Department *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 PATIENT: _____ DATE:_____
REVIEW BY CLINIC STAFF: _____ DATE:_____

Clinic Use Only:

Patient has revoked consent for: ☐ All Services ☐ Vaccines Only, specify _____

☐ Other, specify _____ on (date)_____ at (time) _____.

Clinic Staff Signature: _____ Date: _____