Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

School Wellness Program
Consent for Treatment, Privacy Acknowledgement, Payment Agreement & Questionnaire

Student's Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State:_____ Zip:_____

Grade: _____ School: _____ Male_____ Female _____

Legal Guardian Name: _____ Relationship to Patient: _____

Guardian Date of Birth: ____/____/____ Phone Number: _____

Legal Guardian Name: _____ Relationship to Patient: _____

Guardian Date of Birth: ____/____/____ Phone Number: _____

Name of Patient's Insurance: _____ Beneficiary ID#: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #:_____

Total Annual Family Income. (Please circle appropriate box)

1 member	0-$15,960	15,961-21,280	21,281-26,600	26,601-31,920	$31,921 +
2 members	0-$21,640	21,641-28,853	28,854-36,067	36,068-43,280	$43,281 +
3 members	0-$27,320	27,321-36,427	36,428-45,533	45,534-54,640	$54,641 +
4 members	0-$33,000	33,001-44,000	44,001-55,000	55,001-66,000	$66,001 +
5 members	0-$38,680	38,681-51,573	51,574-64,467	64,468-77,360	$77,361 +
6 members	0-$44,360	44,361-59,147	59,148-73,933	73,934-88,720	$88,721 +
7 members	0-$50,040	50,041-66,720	66,721-83,400	83,401-100,080	$100,081 +
8 members	0-$55,720	55,721-74,293	74,294-92,867	92,868-111,440	$111,441 +

Ethnicity (Please circle)

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (Please circle)

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

Are you homeless? ☐ Yes ☐ No

If yes, please circle:

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

1. We provide enrollment assistance to uninsured and underinsured to obtain health insurance. Would you like us to contact you about this? _____Yes _____No

2. Is English your primary language? _____Yes _____No
   If no, what language are you best served in? _____

Delegation of Consent for Treatment of Your Child: You may appoint individuals over the age of 18 to authorize treatment in your absence. As the parent or legal guardian of the above-named minor, I 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: _____ Contact Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Name of Primary Care Provider: _____ Telephone: _____

Name of Student's Pharmacy: _____ Date of Last Well Child Exam: _____

Medical and Mental Health History

Medications	Dose	Frequency	Dose

Allergies	Reaction Severity

Self and Family History: List any chronic health conditions and student surgical history below

By signing this form, I acknowledge the following:

Consent for Treatment: I consent to registered nursing services, including but not limited to screening/nursing assessments, case finding, immunization assessment, and administration, first aid for minor injuries, chronic care interventions, hearing and vision screening, blood pressure monitoring, blood glucose monitoring, case management and/or referral to other needed primary care and specialty medical services. I consent to routine diagnostic procedures, including but not limited to blood draws, laboratory tests, and administration of medication, and to medical treatment rendered by physicians and staff of Thunder Bay Community Health Service, Inc. 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 by law, the Michigan Public Health Code, if a Thunder Bay Community Health Service employee or associate receives an open wound, percutaneous, or mucous membrane exposure to my child's blood or other body fluids, my child's blood may be drawn, and HIV (AIDS) testing may be performed without my prior written consent. **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 wellness center.**

Sharing Health Information: Under the Health Insurance Portability and Accountability Act (HIPAA), a healthcare 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 consent to sharing information with my child's primary care provider as identified on this consent form for coordination of care.

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, and physical and sexual abuse counseling & referral. I understand that all healthcare information is confidential. Confidentiality between the student, parent/guardian, and the therapist is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The SBHC staff will encourage every student to involve his/her parent/guardian in health care decisions.

Authorization for Payment Agreement: We participate with many insurance carriers, including Medicare and Medicaid, and offer a sliding fee discount program based on family size and income. We will bill your insurance carrier directly for our services as a courtesy. I authorize any insurance benefits to be paid directly to Thunder Bay Community Health Service, Inc.

Privacy Practices Notice: I acknowledge being offered a copy of the Thunder Bay Community Health Service, Inc. Notice of Privacy Practices available at www.tbchs.org or by request.

I understand this consent is valid for a year from its signing date. I understand I may withdraw this consent at any time by providing a statement in writing.

Guardian Printed Name: _____

Guardian Signature: _____ **Date:** _____

REV 7/2022, 8/2022, 4/2023, 11/2023, 3/2026