Treatment Agreement
School Health Centers

Services Provided at
Northeast Health Center/Parkside Health Center
Jackson High Health Center/Northwest Community Health Center

(*) Current Michigan Law states that these services do not require parental consent

- Physicals exams for school, sports, and camp
- Treatment for acute & chronic, illness & injuries
- Vision/hearing screenings and follow-up
- Dental exams, cleanings, x-rays
- Immunizations
- Basic laboratory services & tests
- Crisis Intervention*
- Administration of medication
- Referrals for specialty services
- Substance abuse education, counseling & referrals*
- Gynecological services*
- Pregnancy testing and referrals*
- Sexually transmitted disease screenings, treatment, and counseling*
- HIV screening and referrals*
- Physical/sexual abuse counseling & referrals*
- Individual, group, family, and community education
- Mental health and psycho-social assessment, counseling, & referrals* (if patient is 14 an older)

SERVICES NOT PROVIDED

No birth control pills or devices are dispensed or prescribed

No abortion counseling, referrals or services provided

Authorization for Treatment

Patient Name: ____ **D.O.B.:**_______________

❑ **Medical**: I, hereby voluntarily request, consent to, and authorize Center for Family Health physicians, nurse practitioners, physicians assistants, behavioral health clinicians or other practitioners to provide medical and surgical treatment including but not limited to, diagnostic procedures, lab testing, and administration of medications, as is deemed necessary and advisable.

❑ **Dental:** I hereby voluntary request, consent to, and authorize Center for Family Health dentists, hygienists to provide dental treatment including but not limited to dental exams, cleanings, x-rays, sealants, and fluoride treatments.

My signature indicates I have read both sides of this form and I am giving consent to medical and/or dental treatment and the terms below.

Signature of Parent or Guardian: ____________________________ **Date:** ________________

Relationship to Patient_______________________________________ **Date:** ________________

- I understand parental consent is required for services at any of the School Health Centers for students under the age of 18 and services can be provided without my presence. Crisis intervention and emergency care do not require parental consent. I understand that I may withdraw my permission for services upon written notice to any of the School Health Centers at any time

- I further understand and acknowledge that an HIV test may be performed upon me or my child, without written consent, under the circumstances that a Center for Family Health employee sustains exposure to my blood or other bodily fluids

PLEASE READ OTHER SIDE

Agreement to Pay for Services

- I authorize Center for Family Health to release my medical information necessary to Medicare, Medicaid, or other insurance carrier, to process claims and further authorize payment of medical benefits payable directly to Center for Family Health.

- I understand that Center for Family Health will file and complete the necessary steps to collect my insurance payment.

- I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at the Center for Family Health according to the sliding fee scale. This includes any deductibles or co-payment portions of my bill after insurance payment.

Authorization and Consent to Access, Use and Disclosure of Protected Health Information to/from Jackson Community Medical Record, LLC

- I consent to, and authorize the Center for Family Health to store my personal protected health information in an electronic health record through the Jackson Community Medical Record, LLC.

- I consent to the Center for Family Health and its designees accessing through and/or using and/or disclosing my individually identifiable health information (medical and dental information) to Jackson Community Medical Record, LLC, for treatment, payment or healthcare operations, including for my continuing care.

- I authorize the release of my treatment notes and test results to my Primary Care Provider for purposes of coordination of care.

Privacy Practice Acknowledgement

- I am aware that the Center for Family Health has a HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.

- I may request a copy at any time by contacting any Center for Family Health site.