Beaumont Teen Health Center - Westwood
25912 Annapolis St, Inkster, MI 48141
313-565-2174 FAX 313-565-2189

Patient Information and Parent Acknowledgement Consent & Authorization Form

Today's Date _____

***Patient Name**_____ **Grade**_____
***Patient Date of Birth** _____ **School**_____
***Patient Cell Number**_____ ☐ Male ☐ Female

Race: White Black Multi-racial American Indian Asian/Pacific Islander Other_____
Ethnicity: Hispanic Non-Hispanic Arabic Non-Arabic Other_____

_____ _____ _____
Home Address **City** **Zip**

Name of current Medication(s) _____ For (condition)_____
Has the patient ever been hospitalized overnight ☐ Yes ☐ No
If yes, Why?_____ Date of hospitalization_____
Family Doctor Name_____ Phone number_____

Medical Information - Does the patient have any of the following? Please Circle YES or NO

Allergies Yes No To what _____	Medication Allergy? Yes No To What_____	Food Allergy? Yes No To What_____ Epi-pen at school? Yes No
ADHD/Mental Health Yes No	Asthma Yes No	Seizures Yes No
Diabetes Yes No	Sickle Cell Yes No	Other (Specify)

Parent Name _____ **Parent DOB**_____ **Parent Cell** _____

Emergency Contact Name/Relation, Phone # _____

Insurance: Name_____ **Numbers**_____
Subscribers: Name_____ **Subscriber's date of birth**_____
Medicaid/MI-Child Plan _____ **ID Number**_____
☐ I do not have medical insurance
☐ Check here if you want us to call you for help getting insurance. Please call 734-282-7171 or stop by the clinic if you would like to get a Medicaid application or to make an appointment.

Family History (M=Mother F=Father S/B=Sister/Brother GP=Grandparent

	None	M	F	S/B	GP		None	M	F	S/B	GP
Allergies						High cholesterol					
Asthma						High Blood Pressure					
Heart Attack Stroke/ before age 55						Heart Attack/Stroke after age 55					
Diabetes						Seizures					
Depression/Mental						Substance abuse (alcohol or drugs)					
Other						Smoking					

Patients are entitled to receive safe effective, adequate and appropriate care regardless of their race, religion, creed, color, national origin, sex, age disability handicap, marital status, sexual orientation or ability to pay.

Referred by: _____ **Turn Over for Consent**

Beaumont

River Rouge Teen Health Center
1460 W. Coolidge Hwy
River Rouge, MI 48218
313.843.1639

Romulus Teen Health Center
9650 Wayne Road
Romulus, MI 48174
734.942.4857

Taylor Teen Health Center
26650 Eureka Road, Suite B
Taylor, MI 48180
734.942.2273

Westwood Teen Health Center
25912 Annapolis Street
Inkster, MI 48174
313.565.2174

PATIENT/PARENT CONSENT TO TREATMENT

Patient Name _____ **Birthdate** _____

Section 1: The Beaumont Teen Health centers provide a wide range of medical care, mental health care, and health education services to adolescents and young adults, including, but not limited to, the following: physicals, immunizations, sick care, first aid, lab tests and prescriptions, skin and nutrition care, hearing and vision screenings, sexually transmitted infection, diagnosis and treatment, HIV counseling and testing, reproductive health education and referral, individual and group counseling and referral and substance abuse prevention, assessment and referral. Services are rendered without regard to sex, race, religion or sexual orientation.

I understand that Michigan law does not require a parent consent for a minor to receive advice or treatment of drug abuse, alcoholism, sexually transmitted diseases, including HIV, reproductive health care, or outpatient counseling. At the health provider's discretion, a parent may be notified if the situation is dangerous or life threatening.

I consent to allow the Beaumont Teen Health Centers to provide treatment, including, but not limited to, the services listed above as the physician and health care staff of the Teen Health Center consider necessary. I understand that I can withdraw my consent at any time by giving notice in writing. If I am signing as a parent/guardian, this consent is valid until the patient turns age 18 years.

I understand that testing for blood borne diseases, including HIV, may be performed without a separate written consent if a health professional, volunteer, student or employee of Beaumont is exposed to the patient's blood or body fluids through skin, mucous membrane or open wound.

Section 2: *Immunizations and Vaccinations.* I understand my child's immunization records from the Michigan Care Improvement Registry will be reviewed. If it is determined that my child needs a vaccination, I give my permission for it to be given at the Beaumont Teen Health Center. I understand that I will be notified of the needed shot(s) and be given time to review the vaccine information sheet(s) before the administration of any immunization(s). I understand that I can withdraw my consent for immunizations at any time by contacting the clinic.

☐ Yes, I agree. ☐ No, I do not agree. Please Initial _____

Section 3: *Authorization to Pay Insurance Benefits to the Beaumont Teen Health Centers and Release of Information.*
I authorize my insurance carrier to pay the Beaumont Teen Health Centers for services rendered to me/my child that are covered under my health insurance plan. I understand I may be responsible for fees and charges if my health care provider does not participate in my health insurance plan. I understand I may be responsible for fees and charges that are co-pays, deductibles, or that are for services that are not covered under my health insurance plan. I also authorize the Beaumont Teen Health Centers to release medical information to any Beaumont Health hospital, facility, entity or physician, or me/my child's primary health care provider for continuity of care. A copy of this authorization may be used in place of the original. I understand that I or my insurance carrier may withdraw this authorization at any time by giving consent in writing. I understand that the facility will protect the information in my medical record, but from time to time the facility must release information regarding the care provided to state or federal regulators. I understand that if a test for certain sexually transmitted infections is positive, the law requires the reporting of the positive result to a public health agency.

I have received a copy of the Beaumont Health Notice of Privacy Practices. I understand that this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

I consent for treatment as stated in above Sections 1, 2, and 3.

Signature of Parent/Guardian _____ **Date** _____

Patient _____ **Date** _____

Rx History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature _____ Date _____

Parent Signature _____ Date _____

Beaumont

Beaumont Teen Health Center-Westwood

YOUR RIGHTS

- You have the right to be treated with respect and dignity
- You have the right to receive care at the Health Center: regardless of race, religion, national origin, sex, sexual preference, ability to pay or handicap.
- You have the right to privacy.
- You have the right to discuss with your health care provider any questions or problems you have.
- You have the right to refuse any treatment that you do not want or do not understand.
- You have the right to understand why certain information is requested or why certain care is suggested.

YOUR RESPONSIBILITIES

What you need to do

- You are responsible for treating health care providers with respect.
- You are responsible for answering questions and telling the truth about your health.
- You are responsible for showing respect and privacy for others using the Health Center.
- You are responsible for asking questions about anything you do not understand.
- You are responsible for telling the Health Center Staff about any changes in your health.