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| |  | | --- | | HEALTH INFORMATION  Please provide any health related or medical information that we should know about your child (chronic illnesses,  surgeries, allergies etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Daily Medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you or your family working with another therapist in the school or community? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please list any mental health or behavioral health concerns that you have about your child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CONSENT FOR SCHOOL-BASED HEALTH CENTER**  **BEHAVIORAL HEALTH COUNSELING SERVICES**  I, the parent/guardian of the above-named student, give consent for my child to receive behavioral health counseling  services provided by Isabella Citizens for Health, Inc. (ICH) in the school setting. These sessions may occur in person, by phone  or secure video format. I understand this consent form will be valid for one year and that I may withdraw my consent for services upon written notice to the school-based health center staff at any time.  I, understand that all healthcare information is confidential. By signing the consent form, I authorize ICH staff and my  child’s regular health care provider (if applicable) permission to communicate and share healthcare information regarding my  child’s mental and physical health for the purpose of continuity and coordination of care with the understanding that this  information will continue to be treated in a confidential manner. Confidentiality between the student, parents and the therapist  is assured. By law, some information requires the student’s signed consent prior to disclosure to anyone, including  parents/guardians. ICH staff will encourage every student to involve his/her parent/guardian in health care decisions.  **I understand that I may choose to contact the therapist by text/email and that this is NOT a protected form of communication. ICH or its employees are not responsible for any information obtained via text/email that is not caused by therapist/employee**  **intentional misconduct.**     I acknowledge being offered a copy of the Isabella Citizens for Health, Inc. *Privacy Practices*notice which is available at [www.isabellahealth.org](http://www.isabellahealth.org/) or by request. I understand that federal and state regulations protect the confidentiality of my child’s  records maintained by this program; Information may be released when the following conditions exist (a) there is a suspected  evidence of child abuse, neglect, or danger to my child; or, (b) a medical emergency requires disclosure to medical personnel;  or, (c) my written permission is given to release this information, which may be authorized to specific agencies or persons on a  separate consent form. By signing this consent form, I certify that I am the legal guardian and/or legal custodian of the student named above. I also understand that by providing an emergency contact person, if I cannot be reached, health care information  regarding the above-named child may be shared between the ICH staff and the emergency contact.                I understand that no student will be denied access to services due to an inability to pay. When available, insurance will be  billed and assistance in enrolling for Medicaid or health insurance is available. Discounts may be available for as low as $ 10.00  per visit for those who qualify based on income and household size and may release information regarding treatment to third party payers for billing purposes.  For students with Medicaid insurance, consent is given to provide Personally Identifiable Information  to the Gratiot-Isabella RESD for the purpose of Medicaid reimbursement of School-Based C4S Services. By signing this form, I am  stating that I have the legal rights and abilities to give permission for this student to receive services through Isabella Citizens for  Health.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_              \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***[Signature] Parent/Legal Guardian*    Date**                      **[Printed]** Name Parent/Legal Guardian         Date | | For more information, or to have your questions answered, please call Isabella Citizens for Health at (989) 953-5320 | |  | | |