Isabella Citizens for Health, Inc.

CONSENT FOR TREATMENT
SCHOOL BEHAVIORAL HEALTH COUNSELING SERVICES

Name of School:	Today's Date:

STUDENT/PATIENT INFORMATION

Last name:	**First:**	**Middle:**	**Grade:**

Student's Primary Care Provider:	**Primary Care Provider Phone Number:**

As a Federally Qualified Health Center, we are required to ask the questions below.
We ask about income to ensure that we offer our lowest cost to patients who qualify for discounts based on household size and income.

Primary Phone:	**Secondary Phone:**	**Work Phone:**	**Birth date:**	**SS #**

Address:	**City:**	**State:**	**Zip Code:**	**PO Box:** **Apt./Lot #:**
Secondary Address:	**City:**	**State:**	**Zip Code:**	**PO Box:** **Apt./Lot #:**

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other (Please Specify): ____________________

Race: ☐White/Caucasian ☐ Asian ☐ Multi-Racial
☐ African American/Black ☐ Native Hawaiian
☐ American Indian/Alaskan Native
☐ Other Pacific Islander ☐ Unknown/Refuse to Report

Ethnicity:
- ☐ Non-Hispanic/Latino
- ☐ Hispanic/Latino
- ☐ Decline To Answer

Sex:
- ☐ Male
- ☐ Female

Household Income: ________________ ☐ Decline to Report
Please specify (circle): Weekly/Monthly/Annually
# of people living in your home: _______

Do you live in public housing? ☐Yes ☐ No
Were you homeless within the last 12 months? ☐Yes ☐No
Parent/guardian custody arrangement
☐ joint legal/physical ☐ sole legal/physical ☐ joint legal/ full physical ☐ other

PARENT/GUARANTOR INFORMATION

Guarantor (if not patient):	Relationship to patient:	Birth date:	Social Security #:
Address:	Phone:	Employer:	

PRIMARY INSURANCE INFORMATION **(Please be sure to present copy of card(s) to receptionist)**

Name of primary insurance:	Subscriber's name:	Birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

Isabella Citizens for Health provides personal assistance with enrollment for Medicaid and other health insurance programs.

Would you like us to contact you about this? ☐ Yes / ☐ No

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone Number:	Alt Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Isabella Citizens for Health. I understand that I am financially responsible for any balance. I also authorize Isabella Citizens for Health or insurance company to release any information required to process my claims.

____ ____________________

Patient/Guardian Signature ***Date***

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____________________

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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 (Individual therapy, Group Therapy, and/or ADHD testing) 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 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.

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[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