Youth Health & Wellness Center

Medical and Counseling Services for Ages 10-21, and their children.
We are located on the Career-Tech Center Campus

Medical Services:
Physicals, Immunizations, Illness and Injury

Confidential Services:
STD Testing, Substance Abuse, Pregnancy Testing and Prevention

Counseling Services:
Short-term, Long-term, Individual and Group sessions

Open on Monday-Friday (8:30 am – 4:30 pm)
Open year round including vacations and summer break.
Call for an appointment: 231-922-6416
All services are charged on a sliding scale based on client's income. Services can also be billed to insurance. We can also help you apply for Medicaid.

Youth Health & Wellness Center
880 Parsons Rd., Traverse City, MI 49686 Ph: 922-6416 Fax: 922-6472
Email address: yhwc@gtchd.org Website: www.gtchd.org

Registration / Billing Information

Pt # _____

(For patients less than 18 years old)

Patient's Name	Date of Birth	Male ☐ Female ☐	Preferred Pronouns:	
Address	City	Zip Code	County	Home Telephone #
Parent/Guardian:	Relationship to Patient:	Parent Work Phone #		Parent Cell #
Name of Emergency Contact	Relationship to Patient:	Telephone #		Cell #

Race: **(Please check one or more)**
☐ Am Indian/Alaskan ☐ Black/African American
☐ White/Caucasian ☐ Asian
☐ Native Hawaiian/Pacific Islander

Ethnicity: **(Please check one or more)**
☐ Arabic ☐ Hispanic
☐ Non-Arabic ☐ Non-Hispanic

Insurance: ☐ **Medicaid** ☐ **BCBS** ☐ **Priority Health** ☐ **Other:**_____ ☐ **No Insurance**

Policy #	**Group #**	**Immunization Coverage?** ☐ **Yes** ☐ **No** **Prescription Coverage?** ☐ **Yes** ☐ **No** **Laboratory Coverage?** ☐ **Yes** ☐ **No**
Member Name:		Birth Date:

Patient Cell # _____

Patient attends: ___ ☐ CTC ___ ☐ TC High ☐ Other: _____ ___ ☐ Not in school

Name of Primary Care Provider _____Primary Care Phone #_____

Date of last visit _____ Reason for last visit: _____

Date of last Well Child Exam or Comprehensive Physical _____

SERVICES PROVIDED AT YOUTH HEALTH AND WELLNESS CENTER (YHWC)

Services at Youth Health & Wellness are available to all youth ages 10-21, and their children.
Our services are offered without regard to a patient's sex, race, religion, gender identity or sexual orientation.

- Physical exams (including comprehensive, school, sports, work, camp) which may include vision & hearing tests, basic lab tests, spirometry, etc.
- Treatment for acute & chronic illness & injuries
- Telehealth appointments for medical and mental health.
- Prescription and over-the-counter medications
- Administration of immunizations (as recommended by ACIP) and TB skin testing
- Referrals for specialty services
- Annual health risk assessment

* Crisis intervention
* Substance abuse education, counseling
* Mental Health services
* Pregnancy testing and referrals
* Sexually transmitted infection testing, treatment and counseling
* HIV education, counseling, testing and referral

**Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent. Information related to these services will be confidential and will not be disclosed without written authorization of the minor unless otherwise required by law such as Child Protective Services and Communicable Disease reporting, or if a life threatening condition is suspected or detected.*

NO birth control pills or devices are dispensed or prescribed at Youth Health and Wellness Center.

Patient Name: _____ Date of birth: _____ Pt # _____

By signing this consent form, I give me consent for the above named patient to receive all provided services listed above at Youth Health and Wellness Center or by a YHWC provider via telehealth. Further, I certify that I am the legal guardian, parent, or representative of the patient named above. This consent will not expire and I understand that I may withdraw my consent for specific service and/or all services at any time by notifying a YHWC staff member and written notice may be requested.

I understand that over-the-counter and prescription medications may be prescribed and dispensed by clinic staff under the supervision of the Medical Director.

I understand that immunizations/vaccines are given in accordance to the recommendations of ACIP which include HPV, Hepatitis A, and Meningitis B.

I authorize the YHWC to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the YHWC and my child's primary care physician to release information to each other for the purpose of continuity and coordination of care.

I authorize Youth Health and Wellness Center and K-Town Youth Care (both Grand Traverse County Health Department teen clinics) to share health information as necessary for the continuity and coordination of care if my child receives services at both clinics.

I authorize the YHWC to release information regarding appointments to my child's school when needed to coordinate services at school. I understand that I may revoke this authorization at any time by contacting the clinic by phone or in writing. A separate release of information is needed to disclose information beyond appointment time and status.

I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics, as well as have the opportunity to give feed back on services and programs through questionnaires, focus groups, or the Student Advisory Committee.

I understand that my/my child's privacy is of the utmost importance to YHWC staff and that health information is always handled in a confidential manner as required by law.

I understand my child may be administered a behavioral risk assessment during their appointment at YHWC.

I understand that I have a right to receive a written copy of the Grand Traverse County Health Department *Notice of Privacy Practices* which is available at YHWC.

I understand that the information I have provided on this form will be used to determine eligibility for payment of medical services based on a sliding-fee scale. I further understand that is my child's responsibility to report any changes in their income or health insurance coverage to YHWC before each visit.

I authorize the clinic to bill insurance, Medicaid or another 3rd party payer, if applicable. If the services are not paid by the third party payer, I understand I may get a bill in the mail for a discounted rate. If there is no 3rd party payer to bill, I understand payment is due at the time of each visit. I may be billed at a discounted rate if my son/daughter is unable to cover the amount due at the time of service. I understand my son/daughter will not be denied services, and unpaid balances will not be sent to collections, due to inability to pay.
I understand that I may call to talk with the provider about my child's health care at anytime; however, any information regarding confidential services to minors protected by Michigan Law will be excluded, unless there is a release on file allowing the provider to share this information.

SIGNATURE OF PARENT /GUARDIAN: _____ DATE:_____
REVIEW BY CLINIC STAFF: _____ DATE:_____

Clinic Use Only:
Parent/Guardian has revoked consent for:☐ All Services ☐Vaccines Only, specify _____
☐Other, specify _____ on (date)_____ at (time) _____.
Clinic Staff Signature: _____ Date: _____

YOUTH HEALTH & WELLNESS CENTER

ADOLESCENT PERSONAL & FAMILY HEALTH HISTORY (< 18 years of age)

Patient Name: _____

Date of Birth: _____

Patient #: _____

1. Do you feel your adolescent is healthy today? □ Yes □ No

Please tell us any concerns you have: _____

_____

2. Is your adolescent allergic to any medicine? □ Yes □ No

If yes, what drug(s)? _____

What happens? _____

3. List any medication your adolescent is taking now and the problem for which the medication was given:

Medication	Dosage	Reason	How long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Has your adolescent ever been hospitalized or had surgery? □ Yes □ No

If yes, please explain below:

Date _____ Problem / Surgery _____

Date _____ Problem / Surgery _____

5. Has your adolescent ever had any serious or sports-related injuries? □ Yes □ No

If yes, explain _____

6. Has there been any change in your adolescent's health during the past year? □ Yes □ No

If yes, explain _____

_____

7. Please check (√) whether your adolescent ever had any of the following health problems. If yes, at what age did the problem start?

	Yes	No	Age		Yes	No	Age
ADD / ADHD	☐	☐		Depression or Anxiety	☐	☐	
Anemia or blood disorders	☐	☐		Kidney / urinary problems	☐	☐	
Asthma	☐	☐		Mononucleosis	☐	☐	
Cancer / Leukemia	☐	☐		Scoliosis	☐	☐	
Diabetes	☐	☐		Seizures	☐	☐	
Heart murmur / heart problems	☐	☐		Guillan-Barre syndrome	☐	☐	
Immune disorders, HIV / AIDS	☐	☐		Concussion / head injury	☐	☐	
Headaches / Migraines	☐	☐		Liver Disease	☐	☐	
Stomach or bowel problems	☐	☐		Vision / hearing / speech problems	☐	☐	
				Learning disability, special education needs	☐	☐	

Please explain any yes answers: _____

_____

_____

_____

Patient Name: _____ Date of Birth: _____ Patient #: _____

8. Regarding Immunizations: the following questions will help us determine if it is safe for your adolescent to receive vaccines.

	Yes	No	Please Explain
Allergy to medication, eggs, food, latex, vaccine components	☐	☐	
Has the adolescent had serious reaction to a vaccination, including the flu or flu mist	☐	☐	
Health problem with lung, heart, kidney, or metabolic disease, asthma, neurologic or neuromuscular disease, liver disease, anemia, or blood disorder	☐	☐	
Has the adolescent, sibling, or a parent had a seizure; have they had a brain or other nervous system problems	☐	☐	
Use of cortisone, prednisone or other steroids, anti-cancer drugs or radiation treatment in the last 3 months	☐	☐	
Has the adolescent ever had Guillain-Barre syndrome	☐	☐	
Does the adolescent have cancer, leukemia, HIV/AIDS, or other immune system problem	☐	☐	
Has the adolescent received vaccines in the last 4 weeks	☐	☐	
Blood Transfusions, IgG or antiviral medication in the past year	☐	☐	
Is the adolescent on aspirin therapy	☐	☐	
Is the adolescent pregnant or may become pregnant	☐	☐	

Family and Social History

9. Have you or any of your adolescent's blood relatives (parents, grand parents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is Yes, please state the age of the person when the problem occurred and their relationship to your teen.

	Yes	No	Unsure	Age at onset	Relationship
Alcoholism / Drugs	☐	☐			
Allergies / Asthma	☐	☐			
Blood Disorders	☐	☐			
Cancer - type:	☐	☐			
Diabetes	☐	☐			
Heart attack or stroke	☐	☐			
High blood pressure	☐	☐			
High cholesterol	☐	☐			
Mental health / Depression	☐	☐			
Smoking	☐	☐			
Other - specify:	☐	☐			

10. With whom does the adolescent live most of the time? (Check all that apply)

◯ Both parents in the same household ◯ Mother ◯ Father ◯ Step Mother ◯ Step Father
◯ Guardian ◯ Brother(s) / ages _____ ◯ Sister(s) / ages _____
◯ Other _____

11. **In the past year**, have there been any changes in your family such as:

◯ Marriage ◯ Serious illness ◯ Change in school ◯ Separation ◯ Loss of job
◯ Births ◯ Divorce ◯ Move to a new house ◯ Deaths ◯ Incarcerations
◯ Other _____

Parent/Guardian Signature _____Date reviewed_____

Provider Signature _____ Date reviewed _____