Beaumont

Teen Health Center-River Rouge
1460 W. Coolidge Hwy., River Rouge, MI 48218
Phone:313 843-1639
Fax: 313 843-1649

Welcome River Rouge Teachers, Staff and Community Members

Hello from your School-Based Healthcare Center, located at River Rouge High School. We are funded by the Oakwood Foundation and Michigan Department of Health and Human Services/Michigan Department of Education with support from the River Rouge School District. ***Students must have an annual consent on file, signed by a parent or guardian, in order to be seen with exception to confidential services.***

OUR SERVICES:

- School, Sport and Camp Physicals
- Immunizations- School Shots
- Sick Care
- Asthma Screening and Management
- Vision and Hearing Testing
- Health Promotion
- Mental and Behavioral Health Counseling Services/ Crisis Management*
- Pregnancy & STI testing*
- HIV testing and counseling*
- Nutrition counseling
- Prevention education
- Michigan Health Insurance Marketplace assistance

*confidential services available

STUDENTS ELIGIBLE FOR OUR MEDICAL SERVICES:

- Wayne County youth and adolescents; ages 10 to 21

ALL STUDENTS ARE ELIGIBLE FOR MEDICAID APPLICATION ASSISTANCE.

- We provide medical care on a sliding fee scale if a student does not have health insurance.
- We will never turn anyone away due to inability to pay.
- We can help parents with the Medicaid application process.
- We accept all insurances.

Clinic Hours:

- Monday 8am – 4pm
- Tuesday 8am- 4pm
- Wednesday 8am-7pm
- Thursday 8am-3:30pm
- Friday 8-12pm

Dr. Huma Khan (Medical Director) • Maureen Murphy (Nurse Practitioner) • Justin Follebout, LMSW
Sylvia Hill (Medical Assistant) • Jeff Cook, Director

These Materials were developed with State of Michigan funds allocated by the Michigan Department of Health and Human Services, Michigan Department of Education and the Oakwood Healthcare Foundation.

DATE:_____

Beaumont Teen Health Center - River Rouge

PATIENT INFORMATION SHEET

PATIENT

Patient's Name		Birth Date.	Age
Street Address	City/State	Zip Code	Email Address
Sex: ☐ Male ☐ Female ☐ Gender _____	Social Security Number	Home Phone	Cell Phone
Race: ☐ American Indian/Alaskan Native ☐ White ☐ Black ☐ Asian ☐ Unknown/Other ☐ Multi-racial ☐ Hawaiian/Pacific Island		Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unknown	Language Spoken at Home
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married		If you are a student, please provide: 1) Name of School: 2) Current Grade:	
Family Physician's Name		Physician's Address	Physician's Phone Number
How did you hear about the River Rouge Teen Health Center?			

EMERGENCY

IN CASE OF EMERGENCY, please give name, address and phone number of a friend or relative not living with:	
Name	Relationship to You
Address, City, State and Zip Code	Phone Number

INSURANCE

Primary Insurance Carrier		Secondary Insurance Carrier	
Subscriber's Name	Relationship to patient	Subscriber's Name	Relationship to patient
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Contract No.	Group No.	Contract No.	Group No.
Does anyone in your family (22 or older) need medical/dental insurance? If yes, please provide their name and phone number			
Name		Phone Number	

PARENT

Patient's information (if patient is under 18 or insurance is in parent's name, please complete)	
FATHER OR GUARDIAN	MOTHER OR GUARDIAN
Name:	Name
Birth Date:	Birth Date:
Work Phone:	Work Phone:
Home Phone:	Home Phone:
Social Security Number:	Social Security Number:
Driver's License No.:	Driver's License No.:

Oakwood

Westwood Teen Health Center
25912 Annapolis St
Inkster, MI 48141
313.565.2174

River Rouge Teen Health Center
1460 W. Coolidge Hwy
River Rouge, MI 48218
313.843.1636

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

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

"CONSENT"

NAME:

MR #:

BIRTHDATE:

PATIENT/PARENT CONSENT TO TREATMENT

Patient Name:_____ Birth Date:_____

J117200 Rev. 10/08, 3/14, 7/15

SECTION 1

The Oakwood Teen Health Centers provide a wide range of medical care, metal health care and health education services to adolescents and young adults, including: physicals, immunizations, sick care, first aid, lab tests and prescriptions, skin and nutrition care- hearing and vision screening, 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.

The Oakwood Teen Health Centers measure the patient's height and weight and record that information in the Michigan Care Improvement Registry's (MCIR) Body Mass Index (BMI) Growth Module. Oakwood Teen Health Centers use the resources and tools in the module to promote healthy weight and lifestyle habits for our patients. Use of the module is optional and you may choose to decline this service. Let us know if you decline.

I consent to allow the Oakwood 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.

I understand that Michigan law does not require a parent to 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 providers discretion, a parent may be notified if the situation is dangerous or life threatening.

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 Oakwood 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 (shot) records from the schools and the Michigan Care Improvement Registry will be reviewed If it is determined that my child needs a required shot, I give my permission for it to be given at the Oakwood Teen Health Center. I understand a letter with the needed shot and a vaccine Information Sheet will be sent home for my review at least 1 week before the immunization is planned, or given to me at the clinic the day the immunization is given. The required shots include DTap/DT/TD/Tdap, Hepatitis B, IPV (polio), Meningococcal (Meningitis), Measles, Mumps, and Rubella (MMR), and Varicella (Chicken Pox). The recommended shots include: Hepatitis A HPV(gardasil) and Influenza (flu). If I agree, I understand that at any time I no longer want my child to be immunized, I can contact the clinic and withdraw, the consent.

☐ Yes, I agree ☐ No, I do not agree. Please initial_____

SECTION 3

Authorization to Pay Insurance Benefits to the Oakwood Teen Health Centers and Release of Information
I authorize my insurance carrier to pay the Oakwood 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 also 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 Oakwood Teen Health Centers to release medical information to any Oakwood Healthcare System 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 notice in writing. I also understand that the facility will protect the information in my medical record, but than 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 consent for treatment as stated in above Sections 1 2 and 3.

Signature of Parent / Guardian _____ Date _____

Patient _____ Date _____

Parental consent to withdraw care or treatment from the Oakwood Teen Health Centers.
☐ Medical ☐ Mental Health

Signature of Parent / Guardian _____ Date

Oakwood

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25912 Annapolis St
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1 460 W. Coolidge Hwy
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734.942.2273

Romulus Teen Health Center
9650 Wayne Road
Suite B
Romulus, MI 48180
734.942.4657

NOMBRE:

NHC#:

FECHA DE NACIMIENTO:

PATIENT/PARENT CONSENT TO TREATMENT
CONSENTIMIENTO DEL PACIENTE/PADRE PARA RECIBIR EL TRATAMIENTO

Nombre del Paciente

Fecha de nacimiento

This is a translated copy of the original and is meant for clarification and educational purposes and is not intended to obtain signatures. Legal signatures should be completed on the English copy.

La presente es una copia traducida del original con fines educativos y de clarificación y no tiene por objeto obtener firmas. Las firmas legales se deben completar en la copia que está en inglés.

J117200 Rev. 10/08 3/14 TNS

Sección 1

Los Centros de Salud para Adolescentes Oakwood ofrecen una gran variedad asistencia médica, asistencia para la salud mental y servicios de educación para la salud para adolescentes y adultos jóvenes, incluyendo: exámenes físicos, inmunizaciones, atención para enfermos, primeros auxilios, exámenes de laboratorio y prescripciones, cuidado de la piel y de la nutrición – revisiones de la vista y la audición, diagnóstico y tratamiento de enfermedades infecciosas de transmisión sexual, consejería y pruebas del VIH, educación para la salud reproductiva y envío con un especialista, consejerías grupales e individuales y envío con un especialista y prevención del abuso de sustancias adictivas, evaluación y envío con un especialista. Los servicios se prestan sin considerar el sexo, la raza, la religión o la orientación sexual.

Los Centros de Salud para Adolescentes Oakwood miden la estatura y el peso del paciente y registran dicha información en el Módulo de crecimiento del Índice de Masa Corporal (IMC) del Registro de Mejoras para la Atención de Michigan (MCIR, por sus *siglas en inglés*). Los Centros de Salud para Adolescentes Oakwood utilizan los recursos y herramientas en el módulo con la finalidad de promover un peso saludable, así como hábitos de vida saludables para nuestros pacientes. El uso del módulo es opcional y usted puede elegir rechazar este servicio. Háganos saber si lo rechaza.

Doy mi consentimiento para permitir que los Centros de Salud para Adolescentes Oakwood proporcionen el tratamiento, incluyendo, pero sin limitarse a, los servicios anteriormente mencionados, en la medida que los médicos y el personal de atención de la salud del Centro de Salud para Adolescentes consideren necesario, entiendo que puedo revocar mi consentimiento en cualquier momento mediante una notificación por escrito. Si estoy firmando como padre/tutor, el presente consentimiento únicamente será válido hasta que el paciente cumpla 18 años.

Entiendo que las leyes de Michigan no requieren que un padre dé su consentimiento para que un menor reciba consejería o tratamiento en lo que concierne al abuso de drogas, alcoholismo, enfermedades de transmisión sexual, incluyendo el VIH, asistencia en la salud reproductiva, o consejería para pacientes externos. A discreción del proveedor de asistencia médica, un padre/madre puede ser notificado en caso que la situación sea peligrosa o ponga en riesgo la vida del *menor*.

Entiendo que las pruebas para enfermedades transmitidas por la sangre, incluyendo el VIH, pueden ser realizadas sin una autorización escrita por separado si un profesional de la salud, voluntario, estudiante o empleado de Oakwood se expone al contacto con la sangre o los fluidos corporales del paciente a través de la piel, membranas mucosas, o una herida abierta.

Sección 2

Inmunizaciones y Vacunas – Entiendo que los registros de inmunización de mi hijo(a) (vacunas) que provengan de las escuelas y del Registro de Mejoras para la Atención de Michigan serán revisados. En caso de que se determine que mi hijo(a) necesita la vacuna que se está requiriendo, doy mi permiso para que se le suministre en el Centro de Salud para Adolescentes Oakwood. Entiendo que una carta con el nombre la de la vacuna requerida y la Hoja de información de la vacuna me serán enviadas a casa con la finalidad de que las revise por lo menos con una semana de anticipación a la fecha planeada para la vacunación, o me será entregada en la clínica el día que se lleve a cabo la inmunización. Las vacunas requeridas incluyen Difteria, Tétanos, Tos ferina (DTP/DT/TDAP), Hepatitis B, IPV (polio), Meningococcal (Meningitis), Sarampión, Paperas, Rubeola (MMR), y Varicela (Viruela). Las vacunas recomendadas incluyen: Hepatitis A VPH (gardasil) e Influenza (gripe). Si estoy de acuerdo, entiendo que en cualquier momento que ya desee que mi hijo(a) sea vacunado(a), puedo ponerme en contacto con la clínica y revocar mi consentimiento.

☐ Sí, estoy de acuerdo ☐ No, no estoy de acuerdo. Favor de poner su inicial

Sección 3

Autorización para pagar la cobertura del seguro a los Centros de Salud para Adolescentes Oakwood y Divulgación de información.
Autorizo a mi compañía aseguradora para pagar a los Centros de Salud para Adolescentes Oakwood por los servicios prestados a mí o a mi hijo(a) que están dentro de la cobertura de mi plan de seguro médico. Entiendo que puedo ser responsable de honorarios y cargos si mi proveedor servicios médicos no participa en mi plan de seguro médico. También entiendo que puedo ser responsable de honorarios o cargos de sean los co-pagos, deducibles, o que se destinen para pagar servicios que no estén cubiertos en virtud de mi plan de seguro médico. También autorizo a los Centros de Salud para Adolescentes Oakwood para divulgar información médica a cualquier hospital, centro, entidad o médico de Oakwood Healthcare System, o a mi proveedor principal de servicios médicos o al de mi hijo(a) para la continuidad de la atención. Una copia de la presente autorización pueda ser utilizada en lugar del original. Entiendo que yo o mi compañía aseguradora podemos revocar la presente autorización en cualquier momento mediante una notificación por escrito. También entiendo que el centro protegerá la información en mi registro médico, pero que periódicamente el centro debe divulgar información con respecto a la atención brindada a las autoridades federales o estatales. Entiendo que si una prueba para ciertas infecciones de transmisión sexual da un resultado positivo, la ley requiere que se envíe el informe de dicho resultado a un organismo de salud pública.

Doy mi consentimiento para someterme al tratamiento como se indica en las Secciones 1, 2 y 3 que se mencionan anteriormente.

Firma del Padre/ Tutor

Fecha

Paciente

Fecha

Consentimiento de los padres para revocar la atención o el tratamiento que proviene de los *Centros de Salud para Adolescentes Oakwood*
☐ Médico ☐ Salud mental

Firma del Padre/ Tutor

Fecha

Oakwood

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

Signature of Patient or Representative _____ Date _____

Relationship to Patient _____

Printed or Typed Name _____

Witness or Signature of Oakwood Employee _____ Date _____

If the patient does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

- ☐ Patient given a copy of the Notice but refused to sign form.
- ☐ Patient unable to sign related to:
  - ☐ Emergency treatment situation
  - ☐ Unconscious
  - ☐ Mentally Incompetent
  - ☐ Language Barrier
  - ☐ Other (explain): _____

_____

_____

Signature of Oakwood Employee _____ Date _____

J126230 (4/03)

Permission to Communicate my Health Information Electronically

RX History Consent

I give permission for my provider to access my pharmacy benefits date 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.

Date _____

Patient Signature _____

Parent Signature _____

Oakwood

CONFIDENTIAL

CHILD & ADOLESCENT HEALTH CENTER

NAME:

M.R. #:

BIRTHDATE:

PARENT/GUARDIAN/ADOLESCENT INITIAL HEALTH HISTORY QUESTIONNAIRE

ADOLESCENT INFORMATION

Why did you come to the clinic today? _____

Sex ☐ Male ☐ Female Age_____ Grade in School _____ Year in college _____

Language(s) spoken in your home: _____

ADOLESCENT MEDICAL HISTORY

Are you allergic to any medicines? ☐ Yes ☐ No Name of medicine _____

Are you taking any medicine now? ☐ Yes ☐ No Name of medicine _____

Do you have any health problems? ☐ Yes ☐ No Problem _____

Have you ever been hospitalized overnight? ☐ Yes ☐ No

If yes, give age hospitalized and describe problem Age_____ Problem_____

Age_____ Problem_____

Have you ever had any of the following illnesses or problems? If yes, check all that apply:

- ☐ Allergies
- ☐ Anemia or blood disorders
- ☐ Asthma
- ☐ Bladder/kidney infections
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Other_____
- ☐ Endocrine/gland disease
- ☐ Hepatitis
- ☐ Headaches/migraines
- ☐ Mental illness or depression
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Rheumatic fever/heart disease
- ☐ Scoliosis
- ☐ Seizures
- ☐ Severe acne
- ☐ Sports injuries or broken bones
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer or digestive problems

FAMILY HISTORY

Please check (✓) below if any of the adolescent's blood relatives, living or deceased, have ever had any of the following problems? (e.g., Place ✓ in column headed "F" if adolesent's father had asthma) See below for column heading explanations.

O = None F = Father GP = Grandparent
M = Mother S/B = Sister/Brother A/U = Aunt/Uncle

	O	M	F	S/B	GP	A/U
Allergies						
Arthritis						
Asthma						
Bleeding disorders/Sickle cell anemia						
Birth defects						
Cancer						
Developmental delay or retardation						
Depression/Suicide/ Mental health problems						
Diabetes						
Eating disorders						
Other (specify)						

	O	M	F	S/B	GP	A/U
Endocrine/gland disease						
Heart attack/stroke/sudden death before age 55						
Heart attack/stroke after age 55						
High blood pressure						
High cholesterol						
Kidney disease						
Lung disease/tuberculosis						
Seizures						
Substance abuse (alcohol or drug problem)						
Smoking						

Comments _____

Provider Signature _____ Date/Time _____

Oakwood

River Rouge Teen Health Center

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 unless you are considered a danger to yourself or others.
- 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.