



To Parent(s) and/or Guardian(s):

The _____ school based behavioral tele-health clinic gives your child an opportunity to be seen by a licensed healthcare provider without having to leave the school. An explanation of the services offered by the school based behavioral tele-health clinic is listed below. You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any services to be rendered.

Description of Services

- Psychiatric services via tele-health through Family Medical Center (FMC)
- Behavioral Health Screening and Assessments
- Treatment services include Cognitive Behavioral Therapy
- Psychoeducation
- Brief-solution focused strategies for symptom and stress management, and improved coping skills
- Insurance enrollment assistance for adolescents that are uninsured or underinsured

Your insurance will be billed for services provided in the clinic. If you do not have insurance, services will be provided on a sliding fee scale that is based on the student’s income. Please contact us if you have any questions or concerns at the following number:

Crisis interventions and emergency care do not require consent. Life-saving interventions MAY be initiated without prior consent. Services NOT provided at school based behavioral tele-health clinic include dispensing contraception and abortion counseling.

Current Michigan Law mandates (requires) confidential services to be available to minors in these areas: pregnancy, sexually transmitted infections (STI) and human immunodeficiency virus (HIV) testing and counseling, behavioral health counseling, substance abuse counseling.

Family Medical Center Staff

Our staff is here to assist you, and we are available to communicate with the parents of each student. We want to know your concerns and be able to keep you updated on your student’s health. State law mandates full confidentiality in certain circumstances. The tele-health works with, and is not meant to replace, your family doctor. Feel free to contact us during office hours.

Our staff includes:

- Mubeen Memon, MD
- Jessica Parsil, Psychologist

_____ Schools Contact Information:

Contact Name _____ Website: _____ email: _____
 Phone: _____
 Hours of Operation: _____

The attached forms (pages 2-7) must be completed and returned to the school staff before your child can be seen at school based behavioral tele-health clinic. Thank you.

School Emblem

school based behavioral tele-health clinic
ENROLLMENT, HEALTH HISTORY
& CONSENT FORM



STUDENT INFORMATION

Given Name: _____ Preferred Name: _____ Gender: _____
Date of Birth: _____ Grade: _____ Social Security #: _____
Address: _____ City/State/Zip: _____
Phone: _____ Email: _____
Race: _____ Ethnicity: _____ Lives with: _____

PARENT/GUARDIAN INFORMATION

Father: _____ Phone (H) _____ (W) _____ (C) _____
Mother: _____ Phone (H) _____ (W) _____ (C) _____
Guardian: _____ Phone (H) _____ (W) _____ (C) _____
Alternate Contact: _____ Phone (H) _____ (W) _____ (C) _____
Emergency Contact: _____ Phone (H) _____ (W) _____ (C) _____

HEALTH INFORMATION

- List any allergies your child may have and any medications your child should **not** take: _____
- List any medications (prescription and/or over-the-counter) your child currently takes and why: _____
- Family Physician/Pediatrician: _____ Phone: _____
- Date of last doctor's visit & Reason: _____
- If we need to call in a prescription, which pharmacy would you like us to call? _____
- Dentist: _____ Last dental visit: _____
- Are shots up-to-date? _____ Yes _____ No _____ Unsure
- Last Menstrual Period _____
- Medical History:** Please check/circle all that apply for your child:

| | |
|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Allergies: Food | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Allergies: Other | <input type="checkbox"/> Elimination Problem: Diarrhea or Constipation |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing or Vision Problem |
| <input type="checkbox"/> Blood Pressure: High Low | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Blood Sugar Problem/Diabetes | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Chicken Pox (age _____) | Other: _____ |

Please describe any of the above responses, indicating if treatment is being provided for the condition, and by whom:



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Insurance Information

Patient Name: _____ **DOB:** _____

Primary Insurance: _____

Person responsible for the Bill: _____ Phone: _____

Insurance ID Number: _____ Group Number: _____

Name of Subscriber: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Policy Holder's Social Security Number: _____ Place of Employment: _____

Patient's Relationship to Subscriber: _____ SPOUSE _____ CHILD _____ OTHER _____ SELF

Secondary Insurance: _____

Insurance ID Number: _____ Group Number: _____

Name of Subscriber: _____ Date of Birth: _____

Policy Holder's Social Security Number: _____ Place of Employment: _____

Patient's Relationship to Subscriber: _____ SPOUSE _____ CHILD _____ OTHER _____ SELF

MEDICAID: Please check one _____ Meridian Health _____ United Healthcare Community Plan _____ Other

ID Number: _____ Group Number: _____

I authorize Family Medical Center of Michigan to release any information necessary to process any medical claims for services provided to myself or family members covered by my insurance policy or required by regulatory or accrediting organizations. I authorize payment of medical benefits be made directly to Family Medical Center of Michigan.

Signature

Date

I understand that I will receive a statement of my account while my insurance is being billed, until it has been paid in full by my insurance or myself. _____ **(Initial)**

I understand that, if my insurance has not paid a claim within 45 days from the date of service, that I am responsible for contacting my insurance company and/or pay the bill myself. _____ **(Initial)**

I understand that I am responsible for my charges at Family Medical Center of Michigan whether I am self-pay, receiving discounted services, or if my insurance does not pay for the charges incurred at Family Medical Center of Michigan. _____ **(Initial)**

_____ **NO HEALTH INSURANCE:** Request Application for Sliding Scale Fee/MI Child/Medicaid



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PatientName:_____D.O.B._____

Patient Acknowledgement of Receipt of Policies and Practices

I hereby acknowledge that I have received a copy of Family Medical Center of Michigan's Notice of Privacy Practices.

Patient Signature Date

Parent or Patient Representative Signature Date

Description of Legal Authority to act on behalf of Patient

I here by acknowledge that I have received a copy of Family Medical Center's Financial Policies

Patient Signature Date

Parent or Patient Representative Signature

Description of Legal Authority to act on behalf of Patient



Financial Policy

As a courtesy to our patients, Family Medical Center of Michigan will file your insurance claim with your primary insurance carrier. Family Medical Center of Michigan will supply you, upon request, with all pertinent information to assist in the filing of a claim to your secondary insurance carrier, or we will be glad to file those secondary insurance claims for you on a one-time basis.

To alleviate any misunderstanding regarding insurance payments, all patients must assign their primary insurance company directly to Family Medical Center. If you want the primary insurance company to pay you directly, Family Medical Center of Michigan will require full payment prior to service being rendered. Secondary insurance payments filed by Family Medical Center of Michigan must be assigned directly to Family Medical Center of Michigan. You will be responsible for all balances not covered by your primary or secondary insurance company.

Michigan law requires that insurance companies pay medical practices within a reasonable amount of time (45 days). If a problem persists, we will ask you to assist us in contacting your insurance carrier. Your insurance coverage is a contractual relationship between you and your insurance carrier, not Family Medical Center of Michigan and your insurance. Therefore, all claims not paid within a reasonable amount of time (45 days for "clean claims") will become your responsibility, for which you will receive a bill.

All patients must read and sign Family Medical Center of Michigan's written financial arrangement prior to services being rendered. Our staff will make every effort possible to clarify any misunderstanding that should occur concerning account balances.

Family Medical Center of Michigan's goal is to create an excellent physician/patient relationship.

Family Medical Center of Michigan uses the following guidelines regarding financial payment:

- 1 All Patients must read and sign Family Medical Center of Michigan's financial agreement prior to services being rendered.
- 2 Insurance payments that have not been received within 60 days after filing will be turned over to the patient's responsibility.
- 3 The practice, at its sole discretion, may establish weekly/monthly payment arrangements to accommodate individual patient needs.
- 4 Patients will receive a statement of account each month indicating the amount that is the patient's responsibility. Payment of your balance is due within 30 days

Example

- 5 If you feel that your insurance company has not paid correctly, it is your responsibility to contact them.
- 6 Patients who do not remit payment in full will be turned over to collection agency. Patients with payment arrangements must comply with their monthly payment plan. Failure to do so will result in turnover to collection agency.
- 7 Co-Payments are required before services are rendered.
- 8 If you do not have insurance or have a sliding fee, payment in full is expected at time of service unless you have made prior payment arrangements with our patient accounts department.
- 9 If you have a delinquent account, you will be required to make a payment on your balance in addition to current service before services are rendered.
- 10 For patients who are eligible for Medicare, we are "participating physicians." This means that we accept Medicare's allowed charge for the services rendered, eliminating the difference between what we charge and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for 20% of the approved charge, plus any deductible. If you have secondary insurance, we will submit a claim to them once for any remaining balance after Medicare has paid. Please remember that although we will accept assignment for Medicare patients, the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered Medicare.
11. In cases of divorce, the parent seeking treatment is ultimately responsible for payment of the bill unless we receive legal documentation stating otherwise.

About Our Notice Of Privacy Practices

Family Medical Center is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in the Notice
- The person to contact for further information about our privacy practice.

Family Medical Center is required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.



**CONSENT FORM TO RECEIVE SERVICES AT THE SCHOOL
BASED CLINIC AND THROUGH TELE-HEALTH**

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Student's Name: _____ **DOB:** _____

I, the parent/guardian of said student, give consent for my child to receive all services at the tele-health clinic. I understand that this consent form is valid for the entire time enrolled in _____ Community Schools or until I provide the clinic staff with written directions otherwise.

HIPPA/FERPA: All healthcare information is confidential. By signing the consent form, you are giving the tele-health clinic permission to communicate and share medical information with your child's primary care doctor regarding your child's medical condition on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner. By signing the consent form, I acknowledge I have been offered a copy of the Notice of Privacy Practices (available at the school nurse's office or website <http://www.familymedicalmi.org>).

No student will be denied access to healthcare services due to the inability to pay. As in any health clinic, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing services.

Confidentiality between the student, parents and the health clinic is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact..

Signature of Parent/Legal Guardian

Date

Staff Signature

Date