Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

CONSENT FOR TREATMENT
SCHOOL BASED COUNSELING SERVICES

Student Name_____ Student SS# _____

Address_____ City/State/Zip_____

Date of Birth _____ Home Phone/Mobile Phone _____Grade_____

Race: □ White/□Asian/□Native Hawaiian/□Black African American/□American Indian/Alaska Native□ More than one race

Ethnicity: Are you Hispanic or Latino? □ No □ Yes Gender: □ Male/ □ Female/ □ Other /□ Chose not to disclose

Student's Primary Care Provider: _____

Primary Care Provider Phone Number: _____

PARENT/GUARDIAN INFORMATION

(H) Home (W) Work (C) Cell Phone

Mother _____ Phone _____

Father_____ Phone_____

Guardian_____ Phone_____

Emergency Contact _____ Phone_____

STUDENT'S INSURANCE INFORMATION

Primary Health Insurance: ***We may request a copy of your insurance card for billing purposes***

Name of Insurance Company_____

Subscriber's Name _____Subscriber's Date of Birth_____

Contract #_____ Subscriber's Employer_____

Secondary Health Insurance:

Name of Insurance Company_____

Subscriber's Name _____Subscriber's Date of Birth_____

Contract #_____ Subscriber's Employer_____

Thunder Bay Community Health Service, Inc. provides personal assistance with enrollment for Medicaid or other health insurance programs.

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

Consent for Treatment Continued…

Student Name _____ Date of Birth _____

STUDENT HEALTH INFORMATION

Please provide any health related or medical information that we should know about your child (chronic illnesses, surgeries, etc.)_____

_____

Allergies to Medications/Food/Plants/Environmental_____

Daily Medication(s)_____

_____

Please list any special requests or needs that your child may have that we should be aware of_____

_____

_____

CONSENT FOR SCHOOL-BASED 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 Thunder Bay Community Health Service, Inc. in the school setting. I understand this consent form will be valid for the 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 the TBCHS staff and my child's regular doctor (if applicable) permission to communicate and share healthcare information regarding my child's condition for the purpose of continuity and coordination of care with the understanding that this information will continue to be treated confidentially. 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. The SBHC staff will encourage every student to involve his/her parent/guardian in health care decisions.

I acknowledge being offered a copy of the Thunder Bay Community Health Service, Inc. *Privacy Practices Notice* which is available at www.tbchs.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 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 TBCHS staff and the emergency contact.

I understand that no student will be denied access to services due to an inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance will be billed and assistance in enrolling for Medicaid or health insurance is available. Discounts are available for as low as $10.00 per visit for those who qualify. TBCHS may release information regarding treatment to third party payers for billing purposes.

_____ _____

Signature Parent/Legal Guardian Date Printed Name Parent/Legal Guardian Date