Beaumont Teen Health Center - Romulus
9650 Wayne Rd. Romulus, MI 48174 • 734-942-4857 • FAX 734-942-6734
Patient Information & Consent Form

Patient Name_____ **Birth Date**_____

Address_____ **Patient Phone**
_____ Street City State Zip

Parent/Guardian Name_____ **Parent/Guardian Birth Date**_____

Parent/Guardian Phone #

_____

Emergency Contact Name/Relation/Phone #_____

Insurance: Name:_____ **ID Number**:_____

Subscriber Name: _____ **Subscriber DOB**:_____

• I do not have medical insurance.

• Check here if you want us to call you for Medicaid assistance OR stop by the clinic for assistance.

Patient Information

Race: □White □Black □Multi-racial □ American Indian □ Asian/Pacific Islander □ Other
Ethnicity: □Hispanic □Arabic □Other_____

Gender Identity: □ Male/Boy □ Female/Girl □ Third Gender/Non-binary
□ Prefer to self-describe_____ □ Prefer not to say **Sex Assigned at birth**:
□Female □Male □Intersex

Preferred Language □English □Arabic □Other_____ **Deaf** □Yes □No **Blind** □Yes □No

Medical Information

Current Medication(s) _____ **For (condition)**_____ **Date of most recent Physical Exam:** _____ (**MM/DD/YYYY**)

Any surgeries or hospitalizations: YES or NO **If YES Please List** _____

Family Doctor Name_____ **Phone number**_____

Does the patient have any of the following? Please Circle YES or NO

Allergies : Yes No To What:_____	**Medication Allergy**? Yes No To What:_____----_	**Food Allergy**? Yes No To What:_____ Epi-pen at school? Yes No
ADHD/Mental Health Yes No	High Blood Pressure Yes No	Seizures Yes No
Asthma Yes No	Kidney Problems Yes No	Sickle Cell Yes No
Diabetes Yes No	Stomach Problems Yes No	Headaches/Migraines Yes No
Heart Problems Yes No	Smoking/Vapes Yes No	Other: Yes No

Family History (M=Mother F=Father S/B=Sister/Brother GP=Grandparent A/U=Aunt/Uncle)

	None	M	F	S/B	GP	A/U		None	M	F	S/B	GP	A/U
Allergies							High Blood Pressure						

Asthma							Heart attack /Stroke / Sudden Death before 55						
Bleeding Disorder/ Sickle Cell							Heart Attack/Stroke after 55						
Thyroid							High cholesterol						
Kidney Disease							Seizures						
Diabetes							Smoking						
Depression/Mental Health Problems							Substance Abuse (Alcohol or Drugs)						

Turn Over for Consent

Beaumont

BEAUMONT TEEN HEALTH CENTERS CONSENT TO TREATMENT

9650 South Wayne Road
Romulus, MI 48174
Child and Adolescent Health Center – Pierce Teen Health Center – River Rouge 25605 Orangelawn 1460 W. Coolidge Hwy
Redford, MI 48239 River Rouge, MI 48218 313.242.0570
313.843.1639

Child and Adolescent Health Center – Adams 33475 Palmer
Westland, MI 48186
734.728.2423

Teen Health Center – Taylor Teen Health Center - Westwood
26650 Eureka Road, Suite B 5912 Annapolis Street Taylor, MI
48180 Inkster, MI 48174

Teen Health Center – Romulus
734.942.4857 734.942.2273 313.565.2174

Patient Name _____ **Birthdate** _____

Section 1: The Beaumont Teen Health Centers provide medical care, mental health care, and health education services to adolescents and young adults including, but not limited to: physicals; immunizations; sick care; first aid; lab tests and prescriptions; skin and nutrition care; hearing and vision screenings; diagnosis and treatment for sexually transmitted infection; HIV counseling and testing; reproductive health education and referral; individual and group counseling; and substance abuse prevention, assessment and referral. Services are rendered without regard to sex, race, religion or sexual orientation.

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

I consent to allow the Beaumont 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. If a service is provided through telehealth, including live two-way video, audio, or other computer-based services, I agree that I have read and understand the important information on privacy and possible risks in the attached Telehealth Information document. 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 years, unless it is withdrawn in writing.

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 Beaumont 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 records from the Michigan Care Improvement Registry will be reviewed. If it is determined that my child needs a vaccination, I give my permission for it to be given at the Beaumont Teen Health Center. I understand that the vaccine information sheet(s) related to any vaccine that my child is to receive are available for my review at my request. I also understand that the relevant vaccine information sheet(s) will be discussed with me before the immunization(s) is administered to my child. I understand that I can withdraw my consent for immunizations at any time by contacting the Beaumont Teen Health Center.

Yes, I agree. No, I do not agree. Please Initial _____

Section 3: *Authorization to Pay Insurance Benefits to the Beaumont Teen Health Centers and Release of Information.* I authorize my insurance carrier to pay the Beaumont 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 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 Beaumont Teen Health Centers to release medical information to any Beaumont Health 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 stating so in writing. I understand that the Beaumont Teen Health Centers will protect the information in my/my child's medical record, but from time to time the Beaumont Teen Health Centers 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 have received a copy of the Beaumont Health Notice of Privacy Practices. I understand that this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

I consent for treatment as stated in above Sections 1, 2, and 3.

Signature of Patient/Parent/Guardian _____ Date/Time_____

Phone Number(s) _____ Email_____

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