Whitefoord, Inc.
Uniting Community through Health and Education

TEEN CONSENT FORM

I understand that Whitefoord Inc. Family Medical Center can provide comprehensive health services to my teen. **I also understand that I have the right to withdraw this consent at any time upon written notice to the medical director.**

I authorize (check all that applies):

- ☐ **Release of information** from the teen's medical record whenever necessary for payment, continued care or treatment, and healthcare operations.
    - o I further give consent for staff to examine the teen's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.
- ☐ For my teen to receive **medical care** through the Family Medical Center, including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, referrals and other office minor procedures.
    - o **Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian**
- ☐ For my teen to receive **dental care** through the Family Medical Center. This includes periodic dental examinations for my teen, which may include screenings, photographs, radiographs, and any other acceptable methods for the dental evaluation and management of the teen's dental health.
- ☐ For my teen to receive **behavioral health and counseling services**, including one-on-one counseling, community resource referrals and outreach, and coordination of outside resources
- ☐ Participation in **health education** classes and the Fitness Program sponsored/coordinated by Whitefoord Inc. Health Education Department.
- ☐ That in the case of a medical emergency, I give permission to Whitefoord Inc. Health Centers to call **emergency transport** for my teen.

In order for health center staff members to provide services, I authorize staff members to release medical records to my health care provider as needed to assist in the treatment and/or continuity of care for my teen. These records may include the following; immunization records, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, or health care plans. I also authorize other health care providers for the patient listed above to release information to the Family Medical Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into GRITS (Georgia Registry of Immunization Transactions and Services), dental and mental health records. I hereby authorize the Family Medical Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All patients are served regardless of the ability to pay. I hereby authorize the Family Medical Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, Family Medical Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my teen's health condition and maintaining the continuity of my teen's care, 2) payment for health services provided to my teen, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my teen receives his/her health care services. Whitefoord Inc. Health Center providers are not required by law to disclose medical records or other information regarding health care services related to family planning, pregnancy, and teenbirth to parents without the patient's consent.

I have read and understand the above information and give permission for the teen's care as described. *I understand that I have the right to OPT the teen out of any medical testing or treatment.* This consent will last the duration of the teen's time at this school location.

Name of Parent or Legal Guardian (please print):	**Name of Patient (please print):**	
Signature of Parent or Legal Guardian:	**Relationship to Patient:**	**Date:**

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REASON FOR VISIT: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____

Street Address/Apt #: _____ **County:**_____ **City:**_____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Current Primary Care Provider (PCP): _____ ☐ Patient does not have one but would like to make Whitefoord PCP

Date of Birth (mm/dd/yyyy): _____ **Sex:** ☐ Male ☐ Female ☐ Transgender (M-to-F) ☐ Transgender (F-to-M)

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White **Race Cont. :** ☐ Hispanic ☐ More than one race ☐ Other: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Primary Language: _____ **Do you or the patient require a translator?** ☐ Yes ☐ No

Present Housing Situation (check any that apply): ☐ Migrant ☐ Seasonal ☐ Homeless ☐ Public Housing

Does this patient have an advanced directive (legal document stating patient's wishes regarding medical treatment if no longer able to communicate to doctor)? ☐ Yes ☐ No

How did you hear about Whitefoord? Please Specify: _____

Does Patient Attend School? ☐ Yes ☐ No **School Patient Attends:** _____ **Grade:** _____

PARENT/ GUARDIAN INFORMATION

Name: _____ **Relationship to Patient:** _____

Street Address/Apt # (If different from above): _____

Employer Name (if applicable): _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student **Email:** _____

If you are unavailable, do you authorize Whitefoord to discuss the patient's health information with anyone else?: ☐ Yes ☐ No

If yes, please provide: Name: _____ Relationship to Patient:_____ Phone #: _____

Emergency Contact (If different than Parent/Guardian):

Name: _____ **Relationship to Patient:** _____ **Phone #:** _____

Can Whitefoord discuss personnel health information with this individual? ☐ Yes ☐ No

INSURANCE AND FINANCIAL INFORMATION (All fields required)

Financially Responsible Party (financially responsible for payment or primary insurance holder): ☐ Self ☐ Other

If other, Name: _____ Relationship to patient: _____

We offer discount based on a sliding fee scale, giving us your household information would help us determine if you qualify for our sliding fee scale discount:

What is financially responsible party's number of household dependents?: _____

What is financially responsible party's household income? _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐Yearly

Are you covered by medical insurance?: ☐ Yes ☐ No If yes, what type?: ☐ Medicaid ☐ Private ☐ Other: _____

If Medicaid: Medicaid ID #: _____

If Private Insurance: Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #: _____

Do you have dental insurance? ☐ Yes ☐ No *If yes, please fill out the following:*

Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #:_____

Preferred Pharmacy Name: _____ **Preferred Pharmacy Phone Number:** _____

Preferred Pharmacy Address: _____

MEDICAL HISTORY

Has patient accessed, been treated or received care in an Emergency Room in the past 6 months? ☐ Yes ☐ No

Does patient take any medications? ☐ Yes ☐ No *List all medications:*

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Does patient need to take prescribed medications during school hours? ☐ Yes ☐ No	*List all medications:*
When was patient's last well check visit?	Date:
Has patient had any surgery in the past? ☐ Yes ☐ No	Explain:
Has patient had any shunts placed or has an indwelling catheter? ☐ Yes ☐ No	Explain:
Is/was patient a teen parent? ☐ Yes ☐ No	
Is patient pregnant or possibly pregnant? ☐ Yes ☐ No	Due date:
Is patient currently nursing? ☐ Yes ☐ No	
Is premedication with antibiotics needed prior to dental procedures? ☐ Yes ☐ No	Explain:

HAS PATIENT HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Systems Review	Name of the Condition	Yes	No	Age of Onset	Family member with condition? (please specify)
Neurological (Brain) **and Nerve disorders** (ex. Migraines, Seizures)					
Eye disorders					
Ear/Nose/Throat disorders					
Oral/Dental disorders					
Endocrine/gland disease/autoimmune disorders (ex. Diabetes, Hyperthyroidism)					
Lung Disease/Problems (ex. Asthma, Pneumonia)					
Heart Disease/ Problems (ex. Hypertension)					
Gastro-Intestinal disorders (ex. Gallstones, Ulcers)					
Urinary Tract Disease/Problems (ex. Kidney stone, over active bladder)					
Reproductive disorders (ex. HIV, STDs)					
Genital disorders					
Skin disorders (ex. Psoriasis, Eczema)					
Blood /Lymph disorders (ex. Anemia)					
Allergy/Immunology disorders					
Behavioral Health problems/Mental Illness (ex. Depression, Eating Disorder)					
Musculoskeletal/Joint disorders (ex. Scoliosis)					
Developmental Disorders (ex. Autism)					
School/Psycho-social problems (ex. ADD)					
Cancer/Malignancy					
Others (ex. TB, Hepatitis, Chicken Pox)					

ALLERGIES

Does patient have any allergies? ☐ Yes ☐ No

If yes, list all allergies (food, medications, anesthetic, latex, other):

_____

Does patient have an Epi-Pen at school? ☐ Yes ☐ No

DENTAL HEALTH

Would you like to enroll the patient in dental services?	☐ Yes ☐ No
Had a dental cleaning within the last 6 months?	☐ Yes ☐ No
Are you currently experiencing any dental pain or discomfort?	☐ Yes ☐ No

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BEHAVIORAL HEALTH: Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services? ☐ Yes ☐ No