MOTT CHILDREN'S HEALTH CENTER
CONSENT FOR TREATMENT, BILLING,
OBTAINING MEDICAL INFORMATION
and ACKNOWLEDGING PRIVACY NOTICE
and NONDISCRIMINATION STATEMENT

I give my permission to Mott Children's Health Center (MCHC) to provide the following services to me or the minor child named below: counseling, dental, health education, immunizations, medical, mental health, risk assessment and any testing or treatment related to these services. In addition, I understand that my child may participate on a voluntary basis in classroom or Health Center surveys for the purpose of improving programs and services. (Personal identification will not be disclosed in any way.)

I further understand that Michigan Law does not require parental consent for treatment of substance abuse, sexually transmitted infections, pregnancy, contraception over the age of 12 or mental health treatment age of 14.

I understand that testing for blood borne diseases (including HIV (AIDS)) may be performed upon a patient without a separate written consent in the event that a health care employee receives a cut or exposure to my or my child's blood or body fluids.

Health information obtained during visits may be shared with my child's medical provider. (Information including height, weight and Body Mass Index (BMI) Growth Module are recorded in Michigan Care Improvement Registry (MCIR) and are used to promote healthy weight and lifestyle habits. Use of this module is optional and you may decline this service.)

The Health Center shall have the sole discretion to decide which person (employee or contractor) shall give such treatment. I understand the services and treatment listed above do not involve an exact science, and the results are not always known or guaranteed.

I understand that my/my child's picture may be taken for identification and protection purposes, and will become a part of my/my child's record. I authorize the use of photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I hereby give my permission to Mott Children's Health Center to bill any insurance I have and give any medical information to my insurance company that it requests, as applicable. I further understand that I will not be billed for any services provided by Mott Children's Health Center, unless required by law or regulation. Until the Health Center is notified in writing by me, this consent shall remain in full force.

I have read and understand the consent form and I sign it freely and voluntarily.

Privacy Notice and Nondiscrimination Statement: By signing below, I acknowledge that I have received Mott Children's Health Center's Notice of Privacy Practices and Nondiscrimination Statement.

_____ _____

(Date) Patient's Full Name (Please Print) Date of Birth

_____

Signature of Patient or Authorized Representative of Minor

_____

Relationship to Minor

_____

Witness/Interpreter's Signature