



Expanding, Enhancing Emotional Health (E3) & 31N Consent for Services

Services Provided at Honor E3 and 31N Sites

The client has the right to refuse to defer treatment unless intent exists to harm self or others

Parental Consent is required for the following services provided to patients under the age of 18:

- Mental Health and Psycho-social assessment, counseling, and referral (ages 14-17 if receiving more than 12 sessions or more than 4 months of counseling as a confidential mental health service)
- Ages 3-17 if receiving mental health services as a non-confidential service.
- Individual, group, family, and community education
- Referrals for specialty services
- Telehealth services

Current Michigan Public Health Code Law allows for mental health confidential services to minors aged 14-17.

Parental consent is not required for:

- Mental Health and Psycho-social assessment, counseling, and referral (ages 14-17 if receiving up 12 sessions or 4 months of counseling as a confidential mental health service)
- Substance abuse education, counseling, and referrals

Services NOT Provided at Honor E3 and 31N Sites

Per Michigan Law:

- Birth control pills and contraceptive devices are not dispensed or prescribed on school premises.
- Abortion counseling, referrals, or services are not provided.
- Vaccines and administration of medication are not provided.

Parent/Guardian Consent

I consent to the following:

- The named student may receive all services listed above at the Child and Adolescent Health Centers.
- Exchange of healthcare information between the Child and Adolescent Health Centers and the student's primary care physician and other established healthcare providers for continuity and coordination of care according to state and federal laws.
- Release of information regarding treatment to third party payers or others for the purpose of receiving payment for services.
- Assignment of Medical Benefits:
- I authorize my insurance to pay Honor Community Health for all services rendered
- I understand that if I do not assign medical benefits, I may be billed the full cost of services rendered
- I understand that I may be responsible for co-payments, co-insurance and deductibles
- In certain situations, the delivery of care may include telemedicine:
 - My health care provider has explained how the video conferencing technology will be used to affect consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.
 - I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consultation if it is felt that the videoconferencing connections are not adequate for the situation.
 - I understand others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
- By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the above-named student, and the insurance information is current and correct. I understand that I may withdraw my consent or refuse services upon written notice to the health center at any time. (Withdrawal notification can be written directly on this consent form.)

Student Full Name: _____ Date: _____

Primary Parent/Guardian Signature: _____ **OR Student Signature (18+ ONLY):** _____

Secondary Parent/Guardian Signature (**If applicable): _____

Student Information

Last Name			First Name			Middle Initial	
Date of Birth			Social Security #			Student Cell Phone	
Age			Sex	☐ Female ☐ Male ☐ Choose not to disclose			
Grade			School				
Address			City		State		Zip Code
Race	☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Black/African American ☐ More than one race ☐ Hispanic/Latino ☐ Not listed/Choose not to disclose ☐ Middle Eastern/North African						
Ethnicity	☐ Mexican, Mexican American, Chicano/a ☐ Japanese ☐ Cuban ☐ Korean ☐ Puerto Rican ☐ Vietnamese ☐ Guamanian/Chamorro ☐ More than one ethnicity ☐ Asian Indian ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Chinese ☐ Another Asian ethnicity ☐ Filipino ☐ Not listed/Choose not to disclose						
Living Situation	☐ Not Homeless (Family owns/rents a home/apartment) ☐ Transitional Housing (I have been homeless in the past year, but have housing now/ staying in a treatment facility) ☐ Doubling Up (Staying with friends/relatives because I have no other choice) ☐ Staying in a Shelter (Short-term housing such as HOPE, SOS, Haven etc.) ☐ Street (Living outdoors or in a car/camper) ☐ Other Homeless (Living somewhere not meant to be a home – no running water or heat etc.)						

		Are you worried about losing your housing?		☐ Yes ☐ No	
Primary Parent/Legal Guardian Information					
Last Name			First Name		
Date of Birth			Social Security #		
Phone Number			Preferred Language		
Address		City		State	Zip Code
Secondary Parent/Legal Guardian Information <i>**If applicable</i>					
Last Name			First Name		
Date of Birth			Social Security #		
Phone Number			Preferred Language		
Address		City		State	Zip Code
Emergency Contact Information <i>(Complete only if contact is NOT a parent/legal guardian)</i>					
Last Name			First Name		
Phone Number			Relationship to Student		
Student Health History					
Student's Primary Care Physician (PCP)				PCP Phone #	
Date of Last Physical Exam		____/____/____ ☐ I do not remember			
Student's Dentist				Dentist Phone #	
Current Medications	**Please include dosage and reason for taking medication				
	Medication: _____ Dose: _____ Reason: _____ Medication: _____ Dose: _____ Reason: _____				
Allergies	**Please select all that applies and list where indicated				
	☐ Seasonal (dust, hay fever, etc.) ☐ Food: _____ ☐ Bee Stings ☐ Other: _____ ☐ Medication: _____				
Please check if you (student) have any of the following					
☐ Anemia ☐ Asthma ☐ Attention Deficit Disorder ☐ Blood Disease ☐ Cancer ☐ Dental Problems: _____ ☐ Diabetes ☐ Mental Illness ☐ Fainting ☐ Headaches/Migraines ☐ Head Injury ☐ Heart Murmur ☐ Heart Problems: _____ ☐ HIV/AIDs ☐ Hypertension (high blood pressure) ☐ Jaundice ☐ Kidney/Bladder/Urine Problem ☐ Liver Disease ☐ Menstrual Problems: _____ ☐ Pregnancy, Due: _____ ☐ Rheumatic Fever ☐ Seizures (with or w/o epilepsy) ☐ Sickle Cell Trait ☐ Sickle Cell Disease ☐ Sinus Problems ☐ Skin Problems ☐ Stomach Problems ☐ Venereal Disease					
Other health issues/problems not listed: _____					
Family Medical History: <i>Check if any of the student's relatives had any of the following illnesses and note which relative</i>					
☐ Asthma Who: _____ ☐ Hypertension (high blood pressure) Who: _____ ☐ Anxiety other Who: _____ ☐ High Cholesterol Who: _____ ☐ Cancer Who: _____ ☐ Kidney Problems Who: _____ ☐ Death under age 50 Who: _____ ☐ Seizures Who: _____ ☐ Depression Who: _____ ☐ Sickle Cell Anemia Who: _____ ☐ Diabetes Who: _____ ☐ Stroke Who: _____ ☐ Heart Problems Who: _____ ☐ Other Mental Illness Who: _____					
Primary Insurance Information					
Insurance Company			Policy ID #		Group Plan #
Name of Policy Holder			Relationship to Student		
Secondary Insurance Information <i>(If applicable)</i>					



Insurance Company		Policy ID #		Group Plan #	
Name of Policy Holder		Relationship to Student			

HONOR CARES SCHOOL BASED HEALTH CENTER DISCOUNT PROGRAM APPLICATION

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If you have any questions, please contact an Honor staff member. They would be happy to answer any questions.

****You may be eligible for a discount even if you have insurance;**



\\If.you.are.under.70\\AND.receiving.services.at.a.school_based.health.center.site.OR.confidential.services.at.any.Honor.center?report.only.
your

\.If.you.are.paid.every.two.weeks.(bi_weekly)?divide.your.income.in.half.and.report.as.weekly;

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E3 Pt Intake Form 09032026 – SharePoint: Documents/Public/Patient Forms/English