

MICHIGAN MEDICINE

Regional Alliance for Healthy Schools (RAHS)

**Welcome Letter - School Based Health Center**

**NOT A MEDICAL RECORD DOCUMENT**

Dear Student/Parent or Guardian:

Regional Alliance for Healthy Schools (RAHS) is a group of unique school-based health centers providing services at some public and community schools in Genesee, Jackson, and Washtenaw counties. The goal of the RAHS School-Based Health Centers is to help improve the health and well-being of students and families. Healthy students are more successful in school.

**What is the RAHS School-Based Health Center?**

- Our health centers are staffed by physicians, nurse practitioners, and social workers that are available for your physical and behavioral health needs.
- The purpose of this program is to provide quality healthcare in a friendly setting, at a time that is convenient to patients and families. The RAHS Health Center is NOT trying to replace your regular source of healthcare.
- The RAHS Health Center is open and available to ALL youth.

**What can I do to register?**

- Please fill out the attached forms and return them to your school office or to the RAHS Health Center. The enclosed forms include:
  - Consent Forms
  - Health History Questionnaire
  - We also need a copy of the patient's health insurance card

**What happens after I register?**

- By completing the enclosed forms, patients may be seen at the RAHS Health Center during the school day for health concerns and **will be called down for a brief screening visit to obtain basic health information.**
- If the patient is in elementary school, we ask that a parent/guardian be available by phone if they are unable to attend the appointment with their child.
- The RAHS Health Center will bill your insurance company for services received in our centers.

**How is private health information shared?**

Please visit the Michigan Medicine Notice of Privacy Practices website here <http://www.med.umich.edu/hipaa/UMHS-NPPenglish.pdf> or ask at the RAHS Health Center for a copy of our privacy policy. This notice describes how medical information may be shared. Please review it carefully.

Thank you,

*Regional Alliance for Healthy Schools Clinical Team*

**Pathways to Success Academic Campus**

2800 Stone School Rd. Rm. 112  
Ann Arbor, MI 48104  
Phone: 734 973 9167

**Lincoln High School**

7425 Willis Rd. Rm. 304  
Ypsilanti, MI 48197  
Phone: 734 714 9600

**Richfield Public School Academy**

3807 North Center Road  
Flint, MI 48506  
Phone: 810-285-9815

**Carman-Ainsworth High School**

1300 N. Linden Road  
Flint, MI 48532  
Phone: 810-591-5473

**Brick Elementary School**

8970 Whittaker Road  
Ypsilanti, MI 48197  
Phone: 734-714-9606

**Scarlett Middle School**

3300 Lorraine, Rm. 204  
Ann Arbor, MI 48108  
Phone: 734 677 2708

**Ypsilanti Community Middle School**

510 Emerick  
Ypsilanti, MI 48198  
Phone: 734 221 2271

**Kearsley High School**

4302 Underhill Drive  
Flint, MI 48506  
Phone: 810-591-5330

**Armstrong Middle School**

6161 Hopkins Road  
Flint, MI 48506  
Phone: 810-591-2776

**International Academy of Flint**

2820 S. Saginaw Street  
Flint, MI 48503  
Phone: 810-600-5290

**Lincoln Middle School**

8744 Whittaker Rd. Rm. 812  
Ypsilanti, MI 48197  
Phone: 734 714 9509

**Ypsilanti Community High School**

2095 Packard Rd. Rm. 403  
Ypsilanti, MI 48197  
Phone: 734 221 1007

**Beecher High School**

6255 Neff Road  
Mt Morris, MI 48458  
Phone: 810-591-9333

**Pioneer High School**

601 W. Stadium Blvd.  
Ann Arbor, MI 48103  
Phone: 734-997-1862

**Springport Public Schools**

300 W. Main Street  
Springport, MI 49284  
Phone: 517-867-7846

## Frequently Asked Questions

### What services does the Regional Alliance for Healthy Schools at Michigan Medicine provide?

- Physical exams
- Immunizations
- Individual, group and family psychotherapy
- Basic lab tests e.g. urinalysis, rapid strep, venipuncture
- HIV / STI services (e.g. screening, testing, counseling, etc.)
- Telemedicine services
- Referral for resources such as food, shelter, financial issues, transportation
- Health education or Activities Group such as Walking Club, Anger Management, Asthma Program, Peer Mentoring, Youth Advisory Council, Bully Busters, or other groups as determined by need (some programs available to middle and high school students only)
- Health education
- Medications
- Behavioral health screening and management
- Diagnosis and management of acute and chronic illnesses/diseases
- Reproductive health services (e.g. birth control education, pregnancy testing)
- Minor-consented services
- Referral for substance abuse treatment (middle and high school student)

#### 1. Why might the Michigan Medicine use my specimens for research?

Medical research is constantly discovering new ways to identify, prevent and treat illness. Michigan Medicine is committed to advancing research so we can provide our patients with the most effective medical care.

#### 2. Can I consent to only part of this form?

Yes, a patient has the right to cross out sections of the consent they do not want to consent to.

#### 3. Can I withdraw my consent or my child's consent after this form has been signed?

Yes, you may withdraw consent for services by writing to the Regional Alliance for Healthy Schools Based Health center at any time.

**To withdraw from all Michigan Medicine service please mail a letter signed by parent or guardian for minor or the patient for patients 18 and over to:**

Michigan Medicine Revenue Cycle Mid Service (HIM) Release of Information (ROI) Unit  
3621 S. State Street 700 KMS Place Bay 11 - Mid Service Ann Arbor MI 48108-1633  
Fax: 734-936-8571 or call 734-936-5490.

**General Consent for Healthcare Services and Important Patient Information - ADULT**

MRN:  
NAME:  
BIRTHDATE:  
CSN:  
DOS:

**Notice of Privacy Practices (NPP) Acknowledgment:**

I hereby acknowledge I have been offered or received the Michigan Medicine Notice of Privacy Practices.

**General Consent to Receive Health Care Services**

I want to receive health care services from Michigan Medicine including medical, dental, psychological, nursing and/or other health care. Services may include:

- Physical exams, health education and Immunization
- Behavioral health screening and management
- Basic lab tests e.g. urinalysis, rapid strep, venipuncture
- Individual, group and family psychotherapy
- Diagnosis and management of acute chronic illnesses/diseases
- Medication
- HIV / STI services (e.g. screening, testing, counseling, etc)
- Minor-consented services
- Reproductive health services (e.g. birth control education, pregnancy testing)
- Telemedicine services
- Other treatment necessary for my care

I agree that Michigan Medicine can share my information as needed for care or billing and that various departments may contact me. To facilitate my care and medical needs, Michigan Medicine departments may need to provide necessary information about me to other outside healthcare providers. I have a right to discuss my health care with my health care providers at any time. I have the right to agree to or refuse any care. I understand that my health care providers generally will obtain my consent after discussing specific care, therapies and procedures with me. My health care providers will review known risks, expected benefits and alternatives to therapies in those discussions. I may need to give additional consents for invasive procedures and special treatments such as when I receive blood products. It is impossible to avoid certain risks in the practice of medicine. Outcomes may be different for each patient. I may withdraw consent for services by writing to the Regional Alliance for Healthy Schools health center at any time.

**Assignment of Medical Benefits**

I agree that I will be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. This is true except in cases where Michigan or federal law, or an agreement between my insurance company and Michigan Medicine does not allow it. I assign all rights and benefits to Michigan Medicine in order to help the process of paying Michigan Medicine for health care services I received. I agree to help Michigan Medicine follow up on these claims.

**Important Patient Information**

**1. Michigan Medicine is a Teaching and Research Center.** I may receive services from staff and/or trainees chosen and overseen by the teaching staff. Trainees and teachers may read and use my health care records for teaching and research. I agree to donate any excess tissues, specimens or parts of organs that are removed from my body during testing or medical procedures if they are not necessary for my diagnosis or treatment. I allow Michigan Medicine to own, manipulate, analyze, keep, save or throw away this excess tissue. Michigan Medicine may use or share these items with any entity for any legal purpose, including education and research. I understand that my doctor may have developed a treatment or test that I am given. The treatment or test has been approved for use and it is allowed under state and federal law. My doctor may profit from the use of the test or treatment. I understand that I am able to ask my doctor if an invention of theirs will be used in my care.

**General Consent for Healthcare Services and Important Patient Information - ADULT**

MRN:  
NAME:  
BIRTHDATE:  
CSN:  
DOS:

2. **Human Immunodeficiency Virus (HIV)** is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). **Under Michigan law, an HIV test may be done on a patient** if any health care worker or emergency responder comes in contact with that patient's blood or other body fluids. Contact may occur under the skin, in an open wound or through the mucous membranes, which are the tissues that line various openings in the body. If this type of contact occurs, I know that my blood can be tested without my consent. If a test is done, I know that I will receive the test results and counseling as needed.
3. **Communication Methods.** Michigan Medicine uses many ways to communicate with me. The method used will depend on the reason or reasons for the communication. By providing Michigan Medicine with my contact information I agree to receive communications in different methods, for example: automated calls, text messaging, patient portal, emails, etc. I further agree that Michigan Medicine can send me text messages more than three (3) times a week. I understand that I can choose not to participate in some or all of these methods, but I must communicate my wishes to staff. Michigan Medicine may record incoming and outgoing phone calls with me for quality assurance and training purposes.
4. **Telemedicine Services.** I understand that I may receive care through telemedicine services. The limitations of a telemedicine visit include the possibility of not being able to pick up conditions found during a complete physical exam. There may also be technical difficulties like a lost connection or interruption.
5. **Safety and Security.** In the interest of patient, staff and visitor safety, Michigan Medicine reserves the right to inspect or prohibit the use of personally owned devices and equipment including, but not limited to cell phones (including camera and video functions). Smoking and the use of tobacco products and non FDA-approved marijuana products is not allowed in Michigan Medicine facilities. This includes marijuana, non FDA-approved medical marijuana products in all forms, tobacco cigarettes, chewing tobacco and e-cigarettes. Facilities include buildings, grounds, parking lots and inside personal vehicles on Michigan Medicine property. Michigan Medicine is not responsible for loss or theft of any personal property if not placed in a Michigan Medicine-provided safe or secure area.
6. **Photographing or Recording Done by or Arranged by Patients/Families.** Patients, their families, and their friends are not guaranteed a right to photograph or record on Michigan Medicine premises. However, photographing or recording may be permitted using their own devices subject to the following guidelines: 1. Photographing or recording must **stop right away** if directed to do so by Michigan Medicine staff or at any time if it interferes with clinical care or service to patients, patient privacy, security or operations; 2. Families or visitors of a patient may only photograph or record the patient; 3. Patients and visitors may not include other patients or Michigan Medicine faculty or staff without their verbal permission; 4. Photographs and recordings taken by the family or visitors may not be entered into the medical record.

**My signature represents the following (check all that apply):**

- Acknowledgement of NPP Notification**
- General Consent to Receive Healthcare Services**
- Assignment of Medical Benefits agreement**

**I have read and understand the information on this form before I signed it.**

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative (If patient is unable to sign)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (mm/dd/yyyy)

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
Printed Name of Legally Authorized Representative (If patient is unable to sign)

Relationship:  Spouse  Next-of-Kin  Legal Guardian  DPOA for HealthCare

<p><b>MICHIGAN MEDICINE</b></p> <p>Regional Alliance for Healthy Schools (RAHS)</p> <p><b>Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS) – 18 Years of Age and Older</b></p>	<p>MRN: _____</p> <p>NAME: _____</p> <p>BIRTHDATE: _____</p> <p>CSN: _____</p>
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FOR OFFICE  
USE ONLY

To register for the Regional Alliance for Healthy Schools Service please fill out this Health History Questionnaire form.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
(mm/dd/yyyy)

Student's Name: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Language spoken in home \_\_\_\_\_ Needs Interpreter?  Yes  No  
(mm/dd/yyyy)

Sex Assigned at Birth:  Male  Female What name do you like to use? \_\_\_\_\_

Gender Identity: \_\_\_\_\_ Preferred Pronouns: she/her/hers he/him/his they/them/theirs

Your email: \_\_\_\_\_ Your cell number: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

***Providing the following information about ethnic group is strictly voluntary on your part and is not required to register.***

Ethnic Group:  American Indian  African American  Hispanic  Caucasian  Asian  Middle Eastern  
 Multi-racial (please specify): \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_

**Emergency Contact Information**

Contact Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Relationship to student: \_\_\_\_\_ Email: \_\_\_\_\_  
Best way to reach the contact during the school day?  Home  Cell  Work  Email  Other (specify): \_\_\_\_\_  
Additional contact name:  
Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Do you have health insurance?**  No  Yes

Insurance Name (specify): \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Subscriber's date of birth (DOB): \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Do you have a Primary Care Provider (PCP)?  Yes  No Name of PCP: \_\_\_\_\_  
Date of last complete physical exam: \_\_\_\_\_  
Do you have a Dentist?  Yes  No Name of Dentist: \_\_\_\_\_  
Date last seen: \_\_\_\_\_ (mm/dd/yyyy) Was this a routine check-up?  Yes  No  
Does your family have a preferred pharmacy? Name: \_\_\_\_\_ Phone/location: \_\_\_\_\_

**Who lives in your home?**

Name: _____	Relationship: _____
_____	_____
_____	_____
_____	_____

Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS) – 18 Years of Age and Older

MRN: FOR OFFICE USE ONLY
NAME:
BIRTHDATE:
CSN:

Medications: [ ] I do not take any medications

Name of medicine: Dose: Reason for taking: How long? Prescribed by:
[ ]

Allergies: Do you have any allergies to medicine, food, insect stings, bites or seasonal allergies? [ ] No [ ] Yes (please check and list below):

[ ]

Medical Problems: Please check all that apply:

- [ ] Asthma [ ] Seizures/Epilepsy [ ] Depression [ ] Diabetes [ ] ADD/ADHD (Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder)
[ ] Heart Problems [ ] Hay Fever/Allergies [ ] Learning Disability [ ] Anxiety
[ ] Other (specify):

Do you wear any of the following (check all that apply)? [ ] eyeglasses [ ] contacts [ ] hearing device

Have you ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type of surgery?

[ ] No [ ] Yes: If yes, what age? Problem/Type of Surgery?

Family History:

Some health problems are passed from one generation to the next. Have you or any of your blood relatives (parents, grandparents, brothers or sisters), living or deceased, had any of the following problems?

- [ ] Unknown family medical history. [ ] I was adopted, family medical history is unknown

Table with 6 columns: Yes, No, Unsure, Relationship, Maternal or Paternal. Rows include Allergies, Asthma, Cancer, Anxiety, Bi-polar depression, Depression, Other mental illness, Diabetes, Heart attack or stroke before age 50, High blood pressure, High cholesterol, Migraine headaches, Smoking, Substance Abuse, and Others (specify).

<p>MICHIGAN MEDICINE</p> <p>Regional Alliance for Healthy Schools (RAHS)</p> <p><b>Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS) – 18 Years of Age and Older</b></p>	<p>MRN: _____</p> <p>NAME: _____</p> <p>BIRTHDATE: _____</p> <p>CSN: _____</p>	<p>FOR OFFICE USE ONLY</p>
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	Yes	No
<p>1. Would you like to schedule an appointment with our Nurse Practitioner or Physician to discuss any health concerns? .....</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Do you have questions or concerns about your weight or eating habits? ..... Please explain: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Would you like information from our staff regarding:</p> <ul style="list-style-type: none"> <li>• Finding a health care provider (doctor or nurse practitioner)? .....</li> <li>• Finding a dentist? .....</li> <li>• Affordable vision care or glasses? .....</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>4. Would you like to be contacted by our therapist to discuss your emotional well-being or concerns? ..... <input type="checkbox"/> I am already receiving services from a mental health professional.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Are you concerned about your family's income meeting your basic needs? .....</p> <ul style="list-style-type: none"> <li>• Do you need additional food? .....</li> <li>• Do you need additional clothing? .....</li> <li>• Do you need help paying bills for heat and water? .....</li> <li>• Do you need assistance with transportation to medical or school appointments? .....</li> <li>• Are you concerned about housing? .....</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>6. Would you like information regarding:</p> <ul style="list-style-type: none"> <li>• Health Insurance? .....</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered Yes to any of questions in 1-6 above, a member of our staff will contact you.**

**Thank You.**

\_\_\_\_\_  
Printed name of person who completed this form

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date (mm/dd/yyyy)