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, Washtenaw and Wayne 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 https://www.uofmhealth.org/patients-visitors/patients/patient-privacy/notice-privacy-practices 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

Belleville High School
501 W.Columbia Ave.
Belleville, MI 48111
Phone: 734-697-1144

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
235 Spencer Lane
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

99-10073 HIM: 08/2026

MICHIGAN MEDICINE Regional Alliance for Healthy Schools (RAHS) **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 (NPP)**

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
- Basic lab tests e.g., urinalysis, rapid strep, venipuncture
- Diagnosis and management of acute chronic illnesses/diseases
- HIV / STI services (e.g., screening, testing, counseling, etc.)
- Reproductive health services (e.g., birth control education, pregnancy testing)
- Behavioral health screening and management
- Individual, group and family psychotherapy
- Medication
- Minor-consented services
- 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 the 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 understand I must pay any co-pays, deductibles, or other charges not covered 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 give Michigan Medicine the right to collect payment from my insurance and I agree to assist with insurance claims if needed.

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.

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.

Emerging Technologies. Michigan Medicine is committed to advancing healthcare through the development and use of innovative technologies, such as artificial, emerging, and augmented intelligence tools and technology. As part of this commitment, my provider may record our specific interaction to assist in transcribing my health information into my medical record. I understand that I can opt out of a recording at any time and can only do so by telling the specific provider each time that I want to opt out of the recording of that interaction. Opting out will not affect interactions that were previously recorded, but I understand that Michigan Medicine will protect my health information according to state and federal laws.

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)

_____

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

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

General Consent for Healthcare Services and Important Patient Information - ADULT

MRN:
NAME:
BIRTHDATE:
CSN:
DOS:

Important Patient Information – the items listed below do not require patient/guardian consent and are for informational purposes only.

1. **Michigan Medicine is a Teaching and Research Center.** Trainees supervised by teachers may be involved in your medical care, and they, along with other staff, may access your health information for teaching, research, or developing products, some of which might be commercialized. Researchers at Michigan Medicine may also look at your medical records to see if you could participate in future studies and may contact you. To use your health information in these ways, Michigan Medicine must follow state and federal laws, university rules, and keep your information confidential. As allowed by law, Michigan Medicine owns any extra tissues, fluids, or specimens taken from your body during tests or medical procedures and that are not necessary for your diagnosis or treatment. They can use, retain, preserve, manipulate, study, dispose of, or share these materials and your health information with other organizations for any lawful purpose including teaching, research, or product development, as long as they protect your privacy. You won't earn any money if your health information, tissues, fluids, and/or specimens are used in a commercial product. Treatments or tests you receive could have been developed by your provider, which are properly verified to meet all legal standards, and your provider might benefit financially from them.

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. This type of contact can happen through broken skin, an open wound, or mucous membranes (like the eyes, nose, or mouth). If this type of contact occurs, my blood can be tested without my consent. If a test is done, I will receive the test results and counseling as needed.

3. **Safety and Security.** To keep everyone safe, Michigan Medicine may inspect or ban personal devices like cell phones, especially those with cameras or video. Smoking/Vaping, tobacco, and non-FDA approved marijuana products are not allowed at Michigan Medicine. 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.

4. **Photography or Recording Done by or Arranged by Patients/Families.** Patients and families are not guaranteed the right to take photos or videos at Michigan Medicine.
   However, photography or recording may be permitted using their own devices subject to the following guidelines:
   - You must stop recording if asked by staff or if it interferes with care, privacy, safety, or operations.
   - You may only record yourself or your own family member.
   - You cannot include other patients, staff, or faculty without their verbal permission.
   - These recordings cannot be added to the medical record.

5. Advance Directives. You can create an advance directive to identify a person you choose to make decisions for you if you are unable to make decisions or communicate your wishes about your care.

6. **Withdrawing Consent**
   - A patient has the right to cross out sections of the consent that they do not want to consent to.
   - You may withdraw consent for RAHS services by writing to the Regional Alliance for Healthy Schools at any time.

To withdraw from all University of Michigan Health services please mail a letter signed by parent or guardian, or the patient if 18 or older, 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

MICHIGAN MEDICINE

Regional Alliance for Healthy Schools (RAHS)

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

MRN:

NAME:

BIRTHDATE:

CSN:

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: _____/_____/_____ (mm/dd/yyyy) School: _____ Grade: _____

Student's Name: _____ (Last) _____ (First)

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

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:

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MRN:

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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

	Yes	No	Unsure	Relationship	Maternal or Paternal
Allergies	❑	❑	❑	_____	_____
Asthma	❑	❑	❑	_____	_____
Cancer (type: _____)	❑	❑	❑	_____	_____
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	❑	❑	❑	_____	_____

Others (specify): _____

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	Yes	No
1. Would you like to schedule an appointment with our Nurse Practitioner or Physician to discuss any health concerns? ……	☐	☐
2. Do you have questions or concerns about your weight or eating habits? …….. Please explain: _____	☐	☐
3. Would you like information from our staff regarding:		
• Finding a health care provider (doctor or nurse practitioner)? ……..	☐	☐
• Finding a dentist? ……..	☐	☐
• Affordable vision care or glasses? ……..	☐	☐
4. Would you like to be contacted by our therapist to discuss your emotional well-being or concerns? …….. ☐ I am already receiving services from a mental health professional.	☐	☐
5. Are you concerned about your family's income meeting your basic needs? ……..	☐	☐
• Do you need additional food? ……..	☐	☐
• Do you need additional clothing? ……..	☐	☐
• Do you need help paying bills for heat and water? ……..	☐	☐
• Do you need assistance with transportation to medical or school appointments? ……..	☐	☐
• Are you concerned about housing? ……..	☐	☐
6. Would you like information regarding:		
• Health Insurance? ……..	☐	☐

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)