MINNEAPOLIS SCHOOL BASED CLINICS program

Minor Consent and Clinic Registration

a program of the Minneapolis Health Department

Student Information

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

Preferred Name: _____ ***Student ID:** _____

***Birth Date:** _____ ***Social Security Number:** _____

***Sex at birth:** ❑ Female ❑ Male ❑ Intersex ***Gender identity:** ❑ Female ❑ Male ❑ Gender non-binary

***Preferred pronouns:** ❑ She/her ❑ He/Him ❑ They/them ❑ Other:_____

***Street Address:** _____ ***City:** _____ **Zip:** _____

***Language(s) spoken at home:** _____

***Race(s):** ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic/Latino ❑ White ❑ Other: _____

***Ethnicity:** ❑ Hispanic/Latino ❑ Hmong ❑ Multi-racial ❑ Non-Hispanic/Latino ❑ Somali ❑ Other African ❑ Other:_____

Phone: _____ ❑ Cell ❑ Other **Email:** _____

If you go to another clinic, please list it: _____

***School:** ❑ Longfellow ❑ Edison ❑ FAIR ❑ Henry ❑ Roosevelt ❑ South ❑ Southwest ❑ Washburn ❑ Wellstone ❑ Other: _____

How did you hear about the School Based Clinics?

❑ Classroom Presentation ❑ Coach ❑ Facebook ❑ Friend
❑ Parent ❑ School Nurse ❑ SBC Website ❑ Teacher/School Staff
❑ Twitter ❑ Other:_____

Insurance

Services are provided at low or no cost to families whether or not a student has insurance. Insurance is billed whenever possible to help cover the costs of care. We may send a bill for mental health service co-pays if student has private insurance.

Please choose one

❑ **I don't know my insurance info** ❑ **I don't think I have insurance**

Medical Assistance/Public Health Insurance

❑ State of Minnesota ❑ Blue Cross ❑ UCare ❑ MHP ❑ Health Partners

Group Number: _____ Policy Number: _____

Private Health Insurance

❑ BlueCross/BlueShield ❑ Health Partners ❑ Medica ❑ Portico ❑ Preferred One ❑ UCare
❑ Other: _____

Group Number: _____ Policy Number: _____
Policy Holder Name: _____

Signature required on back ↘

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Please initial after each statement to show you have read and understand each statement

Required for All Clinic Visits	**Initial**
1. I am able to understand facts and information.	
2. I understand what may happen to me as a result of my actions.	
3. I believe that the health services I have asked for will benefit me.	
4. I believe that these health services are necessary for my health and well-being.	
5. Involving my parents in this decision would be a problem for me at this time.	
6. I have been given an opportunity to discuss my questions and concerns.	
7. The risks and benefits of the treatment have been explained to me.	
8. I accept the risks and benefits of the treatment I have chosen.	
9. I feel I have been given all the information I need to make this decision about my health care.	
Required for Birth Control and STI Test Visits Only	**Initial**
1. I understand that my sexual activity could lead to pregnancy and/or sexually transmitted disease(s).	
2. I understand that not having sex is the only 100% way to avoid pregnancy and/or sexually transmitted disease(s).	
3. I chose to be sexually active.	
4. I request health services to prevent pregnancy and/or sexually transmitted disease(s).	
5. I understand all the options presented to me to prevent pregnancy and/or sexually transmitted disease(s).	
6. I have no unanswered questions or concerns about the choice I have made to prevent pregnancy and/or sexually transmitted disease(s).	

By signing this form you agree that:

- The statements above are true and represent my current situation. The information discussed today included, but was not limited to, the statements above. I request and consent to reproductive health services.
- If I have health insurance or MA, I also authorize the clinic to release information regarding my care to insurer for the purpose of billing. I hereby authorize and request payment to and mailing of payment directly to the Minneapolis Department of Health & Family Support for any health care benefits due under term of my insurance policy for services rendered. I understand that all information about my health care is private date and will be treated in accordance with Minnesota Data Privacy Laws and HIPAA.

_____

Student Name *please print*

_____ _____

Student Signature Date

Why are we giving you this form to sign?

To let you know how private health information about you may be used, shared and how you can get access to this information. As we care for your health, we learn about you. Some of what we learn becomes part of your medical record and billing records. To protect your privacy the School Based Clinic follows state and federal laws. The Notice of Privacy Practices provides detail about these rules.

Who has access to the information you supply?

1. Upon request, YOU may generally review any information the Clinic collects concerning your care.
2. Upon request, YOUR PARENTS may generally review information the School Based Clinic collects concerning your care, except for the following:
    a. If your clinic visit was related to pregnancy and conditions associated with pregnancy, sexually transmitted diseases, family planning, alcohol and/or drug abuse
    b. You have the right to request that parental access to all of your clinic health information be denied. If you do not want your parents to have access to any of your clinic health information, you must make that request in writing explaining the reasons you do not want your parents to have access to your health information and sign the request. The Clinic will honor your request to deny parental access if your health care provider determines that it would be in your best interests to do so. You can request a "Deny Parental Access Form" from Clinic staff to make your request.
3. School-Based Clinic staff and contractors whose work assignment requires it.
4. Other health care professionals when necessary for providing care for you.
5. If you receive SBC Mental Health Services your service data will be entered into databases shared with researchers, or others for purpose of program monitoring and quality of services evaluation.
6. Child Protection and/or law enforcement agencies on matters relating to suspected child abuse/neglect.
7. State, Federal, and local agencies or health departments may be provided summary information for statistical purposes with all identifying information removed.
8. We may release your information to protect the health or safety of you or others.
9. Our attorney and our attorney's staff if necessary.
10. Others as described in our Notice of Privacy Practice, including when we are required by law, including officials with a valid subpoena, warrant, or court order.

Information will not be given to any other agency or individual without your (or, when appropriate, your parent's) written consent unless authorized by state or federal law.

The School Based Clinic Medical Records are kept separate from any school records. When you leave high school, your records will be securely stored as required by law.

What are your rights when supplying information?
You have the right to refuse to supply the information we request. However, refusal to supply medical history and other information limits our ability to provide quality health care and may result in ineffective treatment or no treatment at all.

Acknowledgement of Receipt of the Notice of Privacy Practices
Our Notice of Privacy Practices provides information of how our clinic may use or share private health information about you for treatment, payment and clinic operations. A paper copy is available at each School Based Clinic or can be found on our web site: https://www2.minneapolismn.gov/government/programs-initiatives/school-based-clinics/forms/.

I acknowledge that I have received a copy of the School Based Clinic Notice of Privacy Practices.

_____
Student Name *please print*

_____ _____
Student Signature Date