

WILL COUNTY HEALTH DEPARTMENT & WILL COUNTY COMMUNITY HEALTH CENTER
CONSENT FOR CONFIDENTIAL MINOR FAMILY PLANNING AND MENTAL HEALTH SERVICES

The staff of the Will County Health Department/Will County Community Health Center considers parental involvement vital. Every minor is encouraged to involve parent(s)/guardian(s) in healthcare decisions. However, confidentiality between the minor and healthcare providers will be ensured in specific service areas designated by the law, and will not be discussed with parent(s)/guardian(s) unless agreed upon by the minor. See below the types of confidential service available to you. The Health Center can provide a wide range of services with a signed parent consent on file, please ask staff for more details.

Confidential services available will include but not limited to the following:

<p>Laboratory Services</p> <ul style="list-style-type: none"> • Pregnancy tests • STI testing and treatment • HPV and Hep-B vaccines** 	<p>Mental Health Services</p> <ul style="list-style-type: none"> • Assessment of stress, depression and adjustment difficulties • Assessment of alcohol & drug problems • Counseling for emotional & behavioral issues • Individual counseling
<p>Reproductive Health Services</p> <ul style="list-style-type: none"> • Education/diagnosis/treatment for sexually transmitted infections • Menstrual problems • Birth Control/exams/provision/prescriptions • Pap Smears • Pregnancy services-tests, prenatal care • Cancer screening & education 	<p>Referrals/Follow Up</p> <ul style="list-style-type: none"> • Health Education Programs • IRIS – Referral Network for Health & Social Services

** Information surrounding immunizations given will be submitted to I-CARE, the Illinois Comprehensive Automated Immunization Registry Exchange. The primary goal of I-Care is to increase the immunization coverage level of Illinois' children. By giving your consent to receive immunizations, you are also consenting transfer of information to I-CARE.

As a patient of the Will County Community Health Center, I understand that the center will not release information about me to anyone without my permission. Clinic staff may not inform my parent(s) or guardian of the fact that I am receiving these services without my permission. The following are a few expectations. Will County Community Health Center may have to tell someone if:

1. An injury or accident happens on clinic property.
2. I tell them that I am being physically or sexually abused.
3. I have done harm or could do harm to myself or someone else.
4. I have a potentially debilitating or lethal condition.

MINOR CONSENT FOR REPRODUCTIVE HEALTH CARE AND CONFIDENTIALITY POLICY

I agree to receive reproductive health services at the Will County Community Health Center. According to the Illinois law, Persons from 12-18 years of age can consent to receive certain health services including: birth control, pregnancy tests, STD testing and treatment, HIV testing, HPV and Hep-B vaccines, and pregnancy related care and counseling.

I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

Signature of Minor/Adolescent Patient: _____

Date: _____

Witness: _____

Date: _____

MINOR CONSENT FOR MENTAL HEALTH CARE AND CONFIDENTIALITY POLICY

I agree to receive mental health services at the Will County Community Health Center. According to the Illinois law, Persons from 12-18 years of age can consent to receive certain mental health counseling or psychotherapy services for up to 8 ninety-minute sessions. After the final session, in consultation with the minor, the mental health provider can determine whether attempting to obtain parental/guardian consent would be detrimental to the minor's wellbeing

I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

Signature of Minor/Adolescent Patient: _____

Date: _____

Witness: _____

Date: _____

WILL COUNTY HEALTH DEPARTMENT & WILL COUNTY COMMUNITY HEALTH CENTER
CONSENT FOR MEDICAL AND BEHAVIORAL HEALTH EVALUATION AND TREATMENT

Medical Consent: I authorize Will County Health Department & Will County Community Health Center and its medical, dental, behavioral health, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including but not limited to: the administration and/or injection of pharmaceutical products and medications and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatment or examinations performed at Will County Community Health Center. I understand that this consent is valid for up to 1 year and that I may stop services at any time I feel it is necessary.

In the course of treatment, treatment may be provided by a student of nursing, medical assistant, or behavioral health student. I will be informed if a student is working with me and I have the right to decline their services.

_____ (Initials) I do not wish to have students provide my care.

Release of Information: I authorize Will County Health Department/Will County Community Health Center to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable Will County Community Health Center to obtain payment for the services provided; and (3) to permit Will County Community Health Center to carry out ordinary health care and business operations such as quality assurance, service planning, and general administration. I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Mental illness or any mental health disorder
- Family planning, pregnancy
- Alcohol or substance use disorders/Treatment
- Sexually transmitted diseases
- Genetic tests or genetic diseases

I am aware that Will County Community Health Center may share information with any of my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits: I assign to Will County Community Health Center all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers, and other third parties who are financially liable for medical care, behavioral health services, or any other treatment provided by Will County Community Health Center.

Financial Obligations: In the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at Will County Community Health Center facilities in accordance with the rates and terms of Will County Community Health Center in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles.

I certify that I have read this form and that I am the patient, or I am duly authorized by the patient, as the patient's representative to execute this form and accept its terms.

Patient or Responsible Party Name (Print): _____

Patient or Responsible Party (Signature): _____

Relationship to Patient (if patient is unable to sign): _____

Date: _____

Witness: _____

(Print & Signature)

Patients under the custody of DCFS must have a "Routine and Ordinary" consent signed by DCFS representative for medical care and a "Mental Health Treatment" consent to receive B.H. services