P.O. Box 956
3030 Long Lane
Evart, MI 49631
(231) 734-6254
Fax: (231) 734-6258

Medical, Dental, Optical and Mental Health Authorization Contract

Youth Resident_______________________________DOB________________________

I/We the undersigned give consent to the authorities of Muskegon River Youth Home Inc. Is hereby authorized to act in loco parentis securing routine medical services, emergency and/or surgical services, routine and complex dental services, routine and/or specialty optical services, along with routine and/or mental health services including tele-psychiatry throughout the duration of the youth resident placement at the facility.

This authorization includes health exams, diagnostic and laboratory testing, specialist consults, prescribing and refilling medication, and updating immunizations.

This authorization allows the above professional provider services that have been rendered to be billed through the insurance carrier.

Please state whether the resident is covered by **Medicaid**:

Yes______________ Medicaid Contract Number:____

No_______________ If no, has the application be made? Yes or No

Is the resident covered by any other Health Insurance? Yes or No

If Yes, please complete the following information and provide a copy of the insurance card.

Name of Insurance____

Contract #____Group #_____________________

Name of Parent/Guardian that is the primary holder of insurance:

____

Policy Holder DOB:___________________________Policy Holder SS#___________________

Street Address____

City____State________________Zip Code___________

Name of Employer____

I/we as the parent/guardian of the above resident minor have reviewed and consent to the contract.

Parent/Guardian Name____

Signature____Date________________