CRAWFORD COUNTY PUBLIC HEALTH

PREVENT • PROMOTE • PROTECT

CONSENT FOR ASSIGNMENT OF BENEFITS: I consent to assign all insurance payments for the services given today to Crawford County Public Health and understand that I am responsible for all co-payments, deductibles, and other amounts not covered by my insurance. I also understand that any outstanding balances over 90 days may be sent to collections.

CHOICE #1: Bill Insurance: Please provide the patient's private insurance, Medicaid, or Medicare card to the clerk to copy if authorizing us to submit to patient's insurance.

Students Name: _____ **Birth date:** _____ **Phone:** _____

SS#: _____ **Male:** ◯ **Female:** ◯ **Address:** _____

City/State: _____ **Zip Code:** _____

Please indicate your nationality by checking all boxes that apply.

◯ Caucasian ◯ Hispanic ◯ Asian ◯ American Indian/Alaskan Native ◯ African American

Primary Ins. Co: _____
I.D. #: _____
Group #: _____
Primary Cardholder: _____
Cardholder's Birthday: _____
Cardholder's SS #: _____

Secondary Ins. Co.: _____
I.D. #: _____
Group #: _____
Secondary Cardholder: _____
Cardholder's Birthday: _____
Cardholder's SS #: _____

IF ONLY UNDER 18

MOTHER/GUARDIAN INFORMATION

Name: _____
Birth Date: _____
Contact Phone#: _____
Employer: _____

FATHER/GUARDIAN INFORMATION

Name: _____
Birth Date: _____
Contact Phone#: _____
Employer: _____

Emergency Contact Name (other than parent): _____ **Phone:** _____

Family Physician: _____

CHOICE #2: The patient/guarantor will self-pay for all services and fees. 1st vaccine costs $21.25, and each additional vaccine is $20.00 each. Please make checks payable to CCPH

IMMUNIZATIONS: I have received & read or have had read to me, the information contained in the Vaccine Information Statement(s) About the vaccines to be received. I've had the chance to ask questions & these were answered to my satisfaction. I understand the benefits/risk of the vaccines to be received. I grant permission for release of this record to medical providers/health depts./schools/ Daycare center/other as may be necessary. I understand this information is being sent to a central registry at the Ohio Department of Health.

AUTHORIZED SIGNATURE: _____ **DATE:** _____

Notice of Privacy Practices: Crawford County Public Health (CCPH) provides information about how we may use and disclose protected health information about you. The notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing this consent. CCPH provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I gave my consent to CCPH to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this clinic. I understand that I have the right to revoke this consent in writing at any time. However, such a revocation shall not affect any disclosure that CCPH has already made in reliance on my prior consent. I under-stand that I have the right to request a restriction or limitation on the medical information CCPH uses or discloses about me for treatment, Payment or health care operations. This request must also be done in writing and I understand that whenever possible CCPH will honor my request.

Specifically, I authorize:

1. CCPH to give my information to the identified insurance carrier(s) for any and all payment activities.
2. CCPH to conduct, plan, and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly or indirectly.

I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may get those changed notices by contacting CCPH by phone or in writing.

Please answer these questions:

1. Is the person to be vaccinated sick today? ⎔ **Yes** ⎔ **No**
2. Does the person to be vaccinated have allergies to medications/vaccines/foods? ⎔ **Yes** ⎔ **No**
3. Has the person to be vaccinated ever had a serious reaction to any vaccines in the past? ⎔ **Yes** ⎔ **No**

AUTHORIZED SIGNATURE: _____ **DATE:** _____

Check which vaccines you want your child to have.

_____**Tdap** _____ **Meningitis** _____**HPV**

FOR CLINIC USE ONLY

Date Administered	Vaccine type	Lot#	Injection Site	VIS Date	Nurse Signature