Van Wert County General Health District-Adult

1179 Westwood Dr., Ste. 300 Van Wert, OH 45891 (419)238-0808

Legal Name: Last ____________________ First __________________ Middle ________________
Street Address &/or PO Box ____ Apartment # ____________
City ____________________________ State _____________ Zip _____________ **Status**: S M W D
Social Security # ________/______/________ Birth date ______ /_____ /_______ Age ______
Home Phone # __________________________________Cell Phone # _________________________________
Email: ____
Primary Care Physician: ____
Emergency Contact: ___________________________Relationship__________________Phone #_______________
Person Responsible for Payment: ____
Primary Insurance: ____________________________ Name on card______________________________________
Birthdate _____________________________ Social Security # _______________________________
ID #__________________________________ Employer Name____
Secondary Insurance: _________________________ Name on Card ______________________________________
Birthdate _____________________________ Social Security # _______________________________
ID #__________________________________ Employer Name____

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to let you know your rights to privacy with respect to your health care information.

I give my consent to the Van Wert County Health Department (VWCHD) to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this clinic. I authorize VWCHD to give information to the identified insurance carriers(s) for any and all payment activities. **A copy of the Privacy statement is hanging up in the waiting room and a copy can be given if asked for by the client.**

Consent related to privacy Notice: 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 these changed notices by contacting VWCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.

Impact SIIS Statewide Immunization Registry Impact SIIS (Statewide Immunization Information System) is a central data processing point which provides an accurate, efficient way to ensure that Ohioans of all ages receive the right vaccinations at the right times without unnecessary repetition. This also ensures a permanent, secure location of your personal health information that can only be accessed by credentialed health professionals. **I understand that this information will be submitted *unless* I complete a separate form for removal.**

Signature for Consent of Release: ____ **Date:** ___________

Consent for assignment of benefits: I give consent for my insurance to be billed for services received today at the Van Wert County Health Department. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of $25.00 will be charged to you for a check returned for insufficient funds, stopped payment or closed account.

Signature ____ Date _________________
Signature ____ Date _________________
Signature ____ Date _________________
OR:
My insurance is not in-network or it is a non-covered service(s). I will ***self-pay*** for all services & fees.
Signature ____ Date _________________
Signature ____ Date _________________
Signature ____ Date _________________

********************** Please complete the back of this form**********************

Patient Name: ____________________________________ Date of birth: _____/_____/________
LAST NAME, FIRST NAME (mo.) (day) (year)

Screening Checklist for Contraindications to Vaccines for Adults:

For patients: The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

Question	Yes	No	Unsure
Are you sick today?	☐	☐	☐
Do you have allergies to medications, food, a vaccine component, or latex? List if applicable:	☐	☐	☐
Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? List if applicable:	☐	☐	☐
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐
Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐	☐

Form completed by:_____________________________________ Date:_________________

Form updated by: _____________________________________ Date:_________________

Form updated by: _____________________________________ Date:_________________

FOR OFFICE USE ONLY:

Form reviewed by: Initials ________ Date ________
Form reviewed by: Initials ________ Date ________
Form reviewed by: Initials ________ Date ________