



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.

Patient Name: _____

Address: _____

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

Phone: _____

Birth date: _____

SS#: _____ **Male** **Female**

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 #: _____

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

Family Physician: _____

CHOICE #2: The patient/guarantor will self-pay for all services and fees.

- The patient **does not** have private insurance or Medicaid/Medicare coverage.
- The patient has insurance but the vaccine or service is not covered by the insurance.
- Crawford County Public Health is a non-participating provider with the patient's health insurance.
- I **do not** give permission for the patient's insurance agency to be billed for services.

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 understand 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 an allergy to a component of the vaccine? Yes No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes No
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? Yes No

AUTHORIZED SIGNATURE: _____ **DATE:** _____

Fluzone
(6 months and older)

Flublok
(9 years old and older)

High Dose Flu
(65 years and older)

AREA BELOW FOR CLINIC OR OFFICE USE ONLY

***VACCINE ADMINISTRATION INFORMATION**

<p>FLUZONE VACCINE <input type="checkbox"/></p> <p>FLUBLOK VACCINE <input type="checkbox"/></p> <p>HIGH DOSE FLU VACCINE <input type="checkbox"/></p>	<p>INFLUENZA BOOSTER <input type="checkbox"/></p> <p>PNEUMOCOCCAL VACCINE <input type="checkbox"/></p>
<p>Date Administered: _____</p> <p>Manufacturer: _____</p> <p>Lot Number: _____</p> <p>Expiration Date: _____</p> <p>Injection Site: RA LA RT LT NASAL</p> <p>Nurse Signature: _____</p>	<p>Date Administered: _____</p> <p>Manufacturer: _____</p> <p>Lot Number: _____</p> <p>Expiration Date: _____</p> <p>Injection Site: RA LA RT LT NASAL</p> <p>Nurse Signature: _____</p>