Moderna Pfizer

HD REG

PVT OR VFC

Jefferson County Health Department 1948 Wiltshire Road Suite1 Kearneysville, WV 25430
Phone 304-728-8416 Fax: 304-728-3319
www.jchdwv.org

PATIENT INFORMATION

Patient's Name _____ _____ _____
(First) (Middle Initial) (Last)

Date of Birth _____ **Age** _____ **SS#** _____ **Gender** _____
(Month/Day/Year)

Do you consider yourself Hispanic/Latino or not Hispanic/Latino?

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Which of the following five racial designations best describes you?

(More than one choice is acceptable)

☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Mailing Address _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____

EMERGENCY CONTACT INOFRMATION

Contact Name _____ **Phone Number#** _____

Initial here for permission to discuss care with the person named above: _____

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES/ GENERAL CONSENT AND DISCLOSURE

The Jefferson County Health Department (JCHD) Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of this notice is available upon request. By signing this form, you acknowledge that the JCHD Notice of Privacy Practices was made available to you.

GENERAL CONSENT: I give permission to The Jefferson County Health Department, it's designated staff and other medical personnel providing services under it's sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, other treatments, and render other health services to the patient identified on this form.

VACCINE INFORMATION: I have read (or had explained) the information contained in the Vaccine Information Statement (VIS) forms about the diseases and vaccines. I understand the benefits and risks of the vaccines. I request the vaccines be given to me or the person named on this record for whom I am authorized to make this request. I understand the provider of these immunizations may release this record to other school personnel for the purpose of determining emergency or other medical needs or providing a record of compliance with applicable school laws/childcare regulations.

Initial ↓ **BILLING CONSENT**

_____ I authorize Jefferson County Health Department (JCHD) to bill my health insurance company for services provided by the Department, and to exchange information necessary to secure payment for services rendered. Such necessary information may include diagnosis, service dates, types of services and other information related to JCHD'S services necessary to process claims. I further authorize JCHD to release information for purposes of fee collection.

_____ I will notify JCHD of any changes in my health insurance coverage as well as any denial information.

_____ I understand that if an insurance payment is made directly to me I am responsible for immediately sending any such payments to JCHD.

_____ I understand that submission of insurance information does not guarantee coverage. It is the policy holder's responsibility to know their coverage plan.

_____ I understand that if the insurance company does not cover the services, I will be responsible for all payments for services rendered.