SCHOOL IMMUNIZATIONS
Consent Form

Patient Name: _____ **Patient Date of Birth:** _____

ALL PATIENTS:
I give my consent for the Knox County Community Health Center (KCCHC) to provide treatment. _____ (Initial)

RELEASE/SHARING OF INFORMATION
I authorize the KCCHC to **release** and **obtain** verbal, written and electronic health information about the above-named client to and from health care providers involved in the medical and/or dental treatment and management of the client's medical or dental care and with specialists we may refer to.

I authorize release of all health information except: _____

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt- out at any time by notifying the office administrator.

I authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

I understand as condition of receiving care with KCCHC, KCCHC may use or disclose my personally identified health information for such treatment, payment and health care operation purposes. These uses and disclosures are more fully explained in the *Notice of Privacy Practices* that has been made available to me and I have reviewed.

I understand the privacy practices described in the *Notice of Privacy Practices* may change over time and that I have a right to obtain any revised *Privacy Notice* by contacting the Knox County Community Health Center to make a request. KCCHC is located at 11660 Upper Gilchrist Road, Mount Vernon, Ohio 43050.

I understand I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

I authorize release of my medical information necessary to process the claim. I also authorize payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

I have received an explanation of the risks and benefits for all services received and my questions have been answered. I also understand I have the right to refuse services at any time. If I refuse services, KCCHC will make efforts to ensure that I understand the implication and potential consequences of refusing or withdrawing consent for services

Who may we discuss and share your health records with during this Annual Consent period?
I give KCCHC authorization to share my health records with:

Name: _____ *Phone:* _____

Name: _____ *Phone:* _____

Signature of Patient (If patient is a minor parent or guardian):_____ **Date**_____

If Minor Relationship to Patient:_____ **Date**_____

Witness Signature: _____ **Date** _____

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Created: 1/1/2020

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

SCHOOL IMMUNIZATIONS

Patient Demographics

Knox PUBLIC HEALTH

Dear Patient: The Health Center provides low cost health care regardless of ability to pay. We are the Medicaid provider of choice; and accept Medicare and several insurance products. If you have these products or are "self-pay" you may qualify for a discount called a ***Sliding Fee Scale***. Nominal fees and payment arrangements are also available. To qualify for the "***Sliding Fee Scale***" you must provide Proof of Income and the household occupancy. (See the Sliding Fee Scale Application for further information.) We are required to collect personal information as a part of our FQHC grant agreement which is how we keep costs low. Thank you for your understanding and cooperation in providing this information.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Previous names / aliases: _____ Date of Birth: _____

SSN: _____-_____-_____ Home Phone: _____ Cell Phone: _____

Address: _____ City:_____ State: _____

Zip Code: _____ County: _____ Student Status: ☐ Full Time ☐ Part Time ☐ Does not apply

How do you prefer to be reminded of your appointment: ☐ Text ☐ Call Email Address: _____
By providing email address you are acknowledging authorization to send correspondence by this medium.

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Language: ☐ English ☐ Spanish ☐ Other Do you need an interpreter: ☐ Yes ☐ No

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Race: ☐ White ☐ African American ☐ Asian ☐ Other (Please Specify) _____ ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown or choose not to disclose

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Gender at Birth: ☐ Male ☐ Female ☐ Other: _____

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Don't Know ☐ Other _____

Primary Care Physician:_____ City / State:_____ Phone: _____

Emergency Contact:

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Emergency Contact Telephone Number:_____

Complete if patient is 18 years of age or younger, attending school, or has a legal guardian:

For all minor patients (18 years of age or under), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent of child are required.

Parent / Guardian Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Current Custody Status: ☐ Parents ☐ Sole Parental Custody ☐ Joint Legal Custody ☐ DSS Custody ☐ Other: _____

Mailing Address (if different than patient): _____

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Patient Name: _____ DOB: _____

Insurance Information:

Primary Insurance:	*Secondary Insurance*:
Insurance Company _____	Insurance Company _____
Participant's Name _____	Participant's Name _____
Participant's DOB _____	Participant's DOB _____
Participant's SSN _____	Participant's SSN _____

Sliding Fee Scale: (required for statistical purposes and financial assistance)

List number of people living in house (Please include self):

Adults (over 18 years of age) _____ **Children** (Under 18 years of age) _____

Annual Household Income (please check one): ☐ Less than $15,000 ☐ $15,000 to $24,999
☐ $25,000 to $34,999 ☐ $35,000 to $49,000 ☐ $50,000 or more

I have reviewed the *Sliding Fee Scale* and I understand that if my financial circumstances change, I can apply for the *Sliding Fee Scale* at any time.

***I *ACCEPT* and have filled out the Sliding Fee Scale Application: _____** (Initial) **(Complete Sliding Fee Application)**

**** I *DECLINE* the Sliding Fee Scale at this time: _____** (Initial) **(Do NOT complete the Sliding Fee Application)**

Living Arrangements:

☐ **Shelter** (Safe havens, temporary overnight housing, armories)	☐ **Doubling Up** (Living with other people for temporary period and move often)	☐ **Permanent Residence** (Own, rent, apartment / room / house)
☐ **Transitional** (Center, Community Home)	☐ **Street** (Sidewalk, car, park, doorway, public or abandoned building)	
☐ **Other** (Hotel, motel, day-to-day single room occupancy)		

Do you live within Mount Vernon city limits: ☐ Yes ☐ No **Are you a veteran**: ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand that I am responsible to let the doctor or staff know of any changes in my, or minor child's health, or demographic information.

I understand that I am responsible for notifying Knox County Health Center if there is a change in the insurance coverage, address or telephone number. I acknowledge that co-payments or nominal fees are due and payable on the day that services are received.

Name of Patient / Responsible Party (please print): _____ **Date:** _____

Signature of Patient / Responsible Party: _____ **Date:** _____

For Staff Use Only

Tdap	Lot Number	Site:
Meng	**Lot Number**	**Site:**

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Nurse: