Public Health
Cass County Health Department

Immunizations $10 each or all 3 for $20
Medicaid is $0 ONLY if Medicaid # provided

Office Use Only:
School: MIDWAY
Clinic Date: 03/29/19

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Sex O Male O Female
Address			Race/Ethnicity
City State Zip		Parent Name	
Medicaid Number (If applicable) Must provide # for $0 copay:		Cell Phone	
Medicaid Provider: O Home State Health O MO Health Net O United Healthcare		O Medicaid O Underinsured O No Health Insurance O Native American or Alaskan Native	
Parent Signature for Consent to Treat:		Date:	

Question		
Is your child sick or had a fever in the last 72 hours?	YES	NO
Does your child have allergies to any foods or medications? (If so, what?) ______	YES	NO
Has your child ever had a serious reaction to a vaccine (if so, which one)?	YES	NO
Does your child have a seizure or brain disorder that may be exacerbated by immunizations?	YES	NO
Does your child have a disorder of the heart, lung, kidney or blood (i.e. asthma requiring medication, diabetes, sickle cell, etc) or suffered from intussusception as an infant?	YES	NO
Does your child have cancer, leukemia, HIV/AIDS or any other immune disorder?	YES	NO
Has your child taken cortisone, prednisone or any other steroids (excluding inhalers or topicals) in the last 4 weeks?	YES	NO
Has your child had a blood transfusion or received blood products in the past year?	YES	NO
Is there a chance your child could be pregnant or plan to become pregnant in the next month?	YES	NO
Has your child received any vaccinations in the last 4 weeks? (if yes, what)? ______	YES	NO

I would like my child to receive:
[ ] TDAP (Required) [ ] MCV-4 (Required) [ ] HPV-9

LOT: U5875AB Exp: 02/14/2020 [ ] Tdap Given	LOT: U6015AA Exp: 10/06/2019 [ ] MCV-4 Given
LOT: N025429 exp: 07/21/2020 [ ] HPV Given	LOT: [ ] OTHER Given
Nurse Signature	Date:

Public Health
Prevent. Promote. Protect.
Cass County Health Department

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, with my signature, authorize The Cass County Health Department, and any employee working under the direction of is facility, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I authorize The Cass County Health Department to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We will adhere to the following financial policy in order to consistently deliver high quality care and services. By Signing below, I agree:

The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.

I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. The Cass County Health Department is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

It is our privilege to provide your medical care. Thank you for your cooperation in agreeing to this consent and financial policy. I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.