COREHEALTH FAMILY WALK-IN CLINIC

Patient Registration - Consent Form

Please fill-out form completely. See the back page of this form for Notice of Privacy Practices.

Patient's Full Name:

Social Security No:

Date of Birth:

Sex: ☐ M ☐ F

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

Street Address:

City, State, Zip:

Emergency Contact:

Email Address:

Emergency Phone:

Local or Cell Phone *(if not home phone)*:

Relationship to patient:

Home Phone:

Employer:

Primary Care Physician:

Work Phone:

Physician Phone:

How did you hear about us?

REASON FOR VISIT:

Was this a work related injury? ☐ Yes ☐ No

Was this the result of a motor vehicle accident? ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF UNDER THE AGE OF 18

Parent/Guardian Name:

Parent/Guardian Employer:

INSURANCE INFORMATION *(MUST be completed for CORE HEALTH to accept insurance)*

Primary Insurance Company:

Co-pay Amount:

Insurance ID or Group Number:

Policy Number:

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT HOLDS THE INSURANCE

Insurance Holder Name:

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse

Insurance Holder Social Security No:

Insurance Holder Birth Date:

Insurance Holder Address:

COMPLETE THIS SECTION ONLY IF THE PATIENT HAS SECONDARY INSURANCE

Secondary Insurance Co:

Co-pay Amount:

Insurance ID or Group Number:

Policy Number:

OFFICE POLICY ON PAYMENT: It is our policy to require payment of all office charges at the time they are rendered, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 2 percent a month or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the under- signed jointly and severally agree to authorize a credit card transaction on their account and pay all costs charged by the collection company and reasonable attorneys fees. Please note, we do not bill third parties for your visit, i.e. Personal Injury Protection Insurance, Lawyers, or other parties.

I have reviewed the COREHEALTH Notice of Privacy Practices and have read the terms and conditions on the back of this form and accept financial responsibility in full for this account. I hereby voluntarily consent to medical evaluation and/or provide medical care or such treatment deemed necessary in the judgment of the provider in attendance.

SIGNED: ______________________ **DATE:** ______________

CORE HEALTH NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION: The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization, and we need this record to provide you with quality care and to comply with certain legal requirements. This notice will describe the ways we may use and share this information.

INSURANCE POLICY: Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with accurate policy information. You are responsible for all deductibles not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We **do not participate** with any Medical Assistance policies. We **do not** bill insurance carriers for Travel Immunizations.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize **COREHEALTH** to release any medical information and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the provider deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization without a further authorization signed by me for release of the information.

USE AND DISCLOSURE: Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.
Reminders/Notifications. Our staff will use your health information to send you follow-up care, referral or appointment reminders. We may also send you information describing changes occurring at **COREHEALTH** such as, address changes, new locations or changes in business hours.
Treatment Information. Your health information may be used to send you information that you may find interesting on the treatment and management of you medical condition. We may also send you information describing other health-related products and services that may be of interest to you.
Payment. We may use and disclose your medical information for payment purposes. We may need to give your health insurance plan information so that your health plan will pay us or repay you for services.
Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of COREHEALTH. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting accreditation, certificates, licenses and credentials we need to serve you.
Law Enforcement. Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.
Workers Compensation. We may disclose health information to workers compensation or other similar programs.
Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include:
- the right to request restrictions on the use and disclosure of your protected health information,
- the right to receive confidential communication regarding your medical condition and treatment,
- the right to inspect and copy your protected health information,
- the right to an accounting of how and to whom your protected health information has been disclosed,
- the right to receive a printed copy of this notice

COREHEALTH DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY POLICIES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMMENTS & COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices you can do so by sending a letter outlining your concerns to this office, attention: Privacy Official : Major Mittendorf – mmittendorf@coreoccupational.com 225-756-2673 10059 Reiger Road Baton Rouge, LA 70809. If you believe that your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the address listed above. You will not be penalized or otherwise retaliated against for filing a complaint.
FOR ADDITIONAL INFORMATION: Please inquire at the reception desk for a copy of the COREHEALTH Privacy Standards.
EFFECTIVE DATE: January 1, 2011

FAMILY WALK-IN CLINIC *Medical Care at Your Convenience.*

COMPREHENSIVE OCCUPATIONAL RESOURCES, LLC

Influenza Vaccine (Flu Shot) Consent Form

10059 North Reiger Road
Baton Rouge, Louisiana 70809
PHONE: 225-456-2330
FAX: 225-456-2300

(Please answer all questions)

1. **Have you ever had an allergic reaction to flu vaccine?** Yes No
2. **Are you allergic to eggs, or egg products?** Yes No
3. **Do you have a history of Guillain-Barre Syndrome?** Yes No
   (illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)
4. **Are you allergic to thimerosal (a mercury-based preservative)?** Yes No
5. **Are you allergic to latex?** Yes No
6. **Do you feel ill today or do you have a fever?** Yes No
7. **If you are female, are you pregnant?** Yes No Week?

Heard about the clinic from:	Newspaper	Physician	Hospital	Street Sign
	Employer	E-mail	Website	Advertisement
	Friend	Relative	Other	

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, NW Health and OsteoScreening and their employees, owners and representatives, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.
Your personal information and results shall be held strictly confidential. I understand Northwest Health and OsteoScreening is not a Medicare participating provider. Insurance/Medicare will not be billed; however, forms/receipts are available for reimbursement.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**	**MI:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTH DATE:	**AGE:** F9EI 9GH98 85H9	5B8 H=A9	: CF G<CH
SIGNATURE:		**DATE:**	

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#:	SANOFI-FLUZONE LOT #	NOVARTIS – FLUVIRIN LOT
EXPIRATION DATE:		
SITE OF INJECTION:	**R / L**	**DELTOID**
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:		

PAYMENT
Cash $ _________ **Check $** _________ **Credit Card $** _________ **FLU GRAM** _____________ **Co. Sponsored** _____________