CARROLL COUNTY
GENERAL HEALTH DISTRICT
Healthy People — Safe Communities

CONSENT FOR EXAMINATION, TREATMENT and PAYMENT

I request Carroll County Health Department to perform an examination and/or lab tests on me. I understand that all reasonable attempts will be made to contact me if any test result ordered by a Health Department physician is abnormal.

In consideration of the above-mentioned services rendered to me by the Carroll County Health Department, I hereby release and forever discharge the Carroll County Health Department and its Trustees, Board Officers, Employees, Clinic Physician and Nursing Staff from all claims, damages, actions and causes of action arising out of any injury or damages resulting from said service or any effect thereof presently known or unknown now and forever in the future.

Every client shall receive equal consideration and not be excluded from participation in or be denied the benefits of or otherwise be subjected to discrimination on the grounds of race, sex, national, origin, color or handicap.

I agree to accept responsibility for any additional and/or follow-up care that may not be available from the Carroll County Health Department. I give my permission to the employees of the Carroll County Health Department and others authorized by them to use information contained in my medical record for statistical purposes, and as required by law, with the understanding that confidentiality will be maintained. Client confidentiality will be upheld without notification to the parent or legal guardian as applicable. We cannot give out any information about you to anyone without your consent. ***EXCEPTION: If you report any physical abuse, sexual abuse, or report feeling suicidal or homicidal, by law, we must find someone to help you.***

The goal of the Carroll County Health Department is to promote the health and well being of all that receive our services. There is no residency requirement to participate in the Carroll County Health Department Reproductive Health Clinic.

Fees for all services are expected on the date of service. For those who may have difficulty paying upon request may set up a payment plan with the billing office, this must be set up prior to the appointment and a payment must be made at the time of service. We accept Medicaid, Private insurance, cash or check and credit card (Fee of 3% or $2.00 whichever is greater) for payment.

My signature verifies that all information provided to the Carroll County Health Department is truthful and accurate to the best of my knowledge. My signature is also agreement to provide payment of all charges at the time of service.

Parent or Client Signature_____ Date of Service_____

Client Name_____ SSN_____ Date of Birth_____

If you have the following insurances Aultcare, Cigna, Medical Mutual, Anthem BC/BS, Tricare, Aetna, Ohio Health Choice, Summa, Priority Health, United Health Care, Health America, Health Smart, Multiplan, Pai, The Health Plan of the Upper Ohio Valley Please fill out the following information so we can bill your insurance correctly and efficiently.

Name of Person who carries the Insurance if Different then client:
Relation to Client:
Date of Birth of Insurance Carrier:
Social Security Number of Insurance Carrier:

Office Use Only
Witness Signature _____ Date of Service _____
Revised 8/15/2018 Initial 9/19/2016

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Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The Carroll County General Health District strongly recommends that initial immunizations be received only after the child has been examined by a licensed physician. The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the child sick today?	☐ Yes	☐ No	☐ Don't Know
2. Does the child have allergies to latex, medications, food, or a vaccine component?	☐ Yes	☐ No	☐ Don't Know
3. Has the child had a serious reaction to a vaccine in the past?	☐ Yes	☐ No	☐ Don't Know
4. Has the child had a health problem with asthma, lung, heart, kidney, metabolic disease (diabetes) or a blood disorder? Is he/she on long term aspirin therapy?	☐ Yes	☐ No	☐ Don't Know
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐ Yes	☐ No	☐ Don't Know
6. If your child is a baby, have you ever been told he/she has had intussusception?	☐ Yes	☐ No	☐ Don't Know
7. Has the child, a sibling, or a parent had a seizure; has the child had brain, or other nervous system problems?	☐ Yes	☐ No	☐ Don't Know
8. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐ Yes	☐ No	☐ Don't Know
9. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐ Yes	☐ No	☐ Don't Know
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No	☐ Don't Know
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes	☐ No	☐ Don't Know
12. Has the child received vaccinations in the past 4 weeks?	☐ Yes	☐ No	☐ Don't Know

Patient Name: _____

Parent/Guardian Signature _____ Date: _____

I have read or have had explained to me the information in the VIS (vaccine information statement) for the vaccine(s) indicated above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and give permission to the Carroll County Health Department to administer the vaccine(s) indicated above to me or the person named to receive the vaccine for whom I am authorized to make this request. I hereby give consent for the release of this health information as may be necessary to the client's physician, school, daycare center, WIC, Medicaid, if applicable, and the Ohio Department of Health Immunization Registry. **I understand that by signing below I accept full responsibility for payment of any claims denied by insurance/Medicaid/Medicare.**

IMMUNIZATIONS TO BE GIVEN TODAY:

___ DTaP	___ HIB	___ Hep B	___ D/I (kinrix)	___ Gardasil	___ Polio	___ Flu
___ D/HepB/I (pdrx)	___ Prevnar	___ MMR	___ Tdap	___ Meningitis B	___ Hep A	
___ D/Hib/I (pent)	___ Rotavirus	___ Varicella	___ Meningitis	___ TD	___ MMRV (proquad)	

Nurse's Signature _____ Date: _____