MIDLAND COUNTY HEALTH DEPARTMENT
CONFIDENTIAL CLIENT INFORMATION

It is your responsibility to check with your health insurance company regarding coverage of specific vaccines. You can refer to our website for a list of insurance companies that we participate with. Payment is due at the time of service. We accept cash, check, Visa, MasterCard and Discover. You will be provided with a detailed receipt at the time of service for your insurance company or personal record. Most HSA accounts are not accepted.

Name:______________________ DOB:______________ Age:_______ Client ID:______________

Gender:______ SS#__________________ Last Name at Birth________________________________

Address:____ Home Phone: (   )_________

Do you have an E-Mail Address? ________________________________ Cell Phone: (   )_________

What is your Ethnicity? Circle one: Hispanic, Non-Hispanic

What is your Race? Circle one: White, American Indian, African American, Alaskan Native, Asian, Native Hawaiian, or Pacific Islander

What is your preferred language?__________________

Change of Address: ____
I have read and verify that the above address is correct. Client's Initials_______

Check one of the following

________ **Enrolled in Medicaid**
________ **Enrolled in Medicare**
________ **No health insurance**
________ **Health Insurance with immunization coverage** ***(you may be responsible for the cost of the vaccines/admin. fees at the time of service. You will be given a receipt to submit to your insurance carrier).***
________ **Health insurance but immunizations not covered**
________ **American Indian or Alaskan Native**

If Employer Is Paying, Provide Employer's Name______________________________________

I verify that the above information is accurate

____
Client, Custodial Parent or Guardian Name (Please Print)

____
Client, Custodial Parent or Guardian Signature **(Today's Date)**

____
Clerks Initials

Midland County Health Department
Consent for Services and Release of Information

Client Name:____ DOB: ________________ Age:_____

Midland County Health Department, its employees or agents may provide applicable services, examination and/or diagnostic testing or treatment. These services are provided confidentially, on a voluntary basis, without my being forced to accept any services or medications.

I understand that information from my record may be shared with the members of my treatment team. My treatment team will be determined by the services I receive, and may include, but is not limited to, a nurse, nurse practitioner, or doctor. In the event of an infestation or infection of a school-aged child, my child's school may be contacted. Childhood immunizations may be shared with the Michigan Childhood Immunization Registry. Any other release of information will require a specific release, signed by the client, custodial parent or guardian, unless the information is otherwise legally required.

I understand that I do not need to receive family planning services to get other services or support from the health department.

Midland County Health Department may release, either verbally or in writing, information contained in my medical, social, or educational records, including HIV, AIDS, or AIDS related information, as is necessary for the authorization and payment of bills for professional services.

I understand that I am responsible for charges due the Health Department and that payment is expected at the time of service.

If a Health Department employee is exposed to blood or body fluids by puncture, or consent to open skin or mucus membrane, the client's blood may be tested for HIV and other infectious diseases without further consent.

As a partner in my health care, I understand that participation and follow through is expected. Services may be terminated due to noncompliance. Examples of noncompliance are: not being at home two times for scheduled home visits, failure to pay fees for which I am responsible, or failure to follow a prescribed treatment.

This authorization will continue in effect through the duration of service associated with this admission or condition, up to one year, or until revoked in writing.

Print Name of the Person authorizing consent:

____

Custodial Parent, Guardian or Client (circle one)____

Signature:____**Today's Date**______________

Clerk's Initials______________

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ____________________

DATE OF BIRTH ___/___/___ (month / day / year)

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY ____________________ DATE ________

FORM REVIEWED BY ____________________ DATE ________

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

Midland County
Department of Public Health

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of the Midland County Department of Public Health Notice of Privacy Practices.

Patient Name (Print) ____________ Patient Signature ____________ Date ____________

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print) ____________ Personal Representative's Signature ____________ Date ____________

Relationship ____________

For Midland County Department of Public Health use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Midland County Department of Public Health Notice of Privacy Practices Acknowledgement, but was unable for the following reason:

____

Employee name ____________ Date ____________

This form should be placed in the patient's medical record