FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

PATIENT REGISTRATION – **PLEASE FILL OUT ALL QUESTIONS ON THIS FORM**

Last Name: _____ **First Name:** _____ **DOB:** _____ **Sex**: **M / F**

If the patient is a minor, please list name of parent or legal guardian here: _____

Address: _____**City:**_____ **State:**_____ **Zip:** _____ **Phone:** _____

Primary Care Physician: _____ **Physician phone:** _____

***Emergency Contact**_____ **Phone** _____
**Please tell us who to contact in case of emergency (parent or guardian if under age 18): An emergency would be severe bleeding, unconsciousness, or an accident or condition requiring ambulance transport or hospitalization.*

We recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage.

INSURANCE/PAYMENT INFORMATION -

No Insurance (NI) [ ] Alaska Native (AN) [ ] American Indian (AI) [ ]

Medicare # _____ Medicaid # _____
Private Insurance Name _____ Policy # _____
Group/Plan # _____ Subscriber's Name & DOB _____

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to disclose of any portion of the patient's medical record necessary to my insurance for reimbursement of services and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

FINANCIAL/WAIVER POLICY

It is my responsibility to understand my insurance benefits and plan coverage. This assignment will remain in effect until revoked by me in writing. By signing this document (below), I understand that if claims are denied due to eligibility status, missing or invalid medical group information or invalid network services, I will assume full responsibility for all charges incurred by me or my dependents. Additionally, I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services, which are provided by Fremont County Department of Public Health & Environment.

_____ _____
Signature Date

Fremont County Department of Public Health & Environment
Health Insurance Portability and Accountability Act (HIPAA)
Provider Notice of Privacy Practices

USES AND DISCLOSURES OF HEALTH INFORMATION: We use health information about you for treatment (diagnostic testing, prescriptions, immunizations, referrals, etc.) to obtain payment (submit claims and/or encounters to billing services) for administrative purposes (reporting, surveys, etc.) and to evaluate the quality of care that your receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may apply a change to our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each exam room. You may also request a copy of our privacy practices by contacting the HIPAA Compliance Officer.

INDIVIDUAL RIGHTS: You have the right, following a written request and agreed upon date and time, to look at, get a copy of or receive electronically protected health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we amend the existing information. You may request in writing that we restrict and/or not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it.

COMPLAINTS: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access or amendment to your records, you may contact the HIPAA Compliance Officer. You may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. The HIPAA Compliance Officer can provide you with the appropriate address upon request.

OUR LEGAL RIGHTS: We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

164.520 Notice of Privacy Practices for Protected Health Information

(a.) *Standard: notices of privacy practices.*

(1) *Right to notice: Except as provided by paragraph* ***(a) (2)*** *or* ***(3)*** *of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information.*

(2) *Specific requirements for certain covered health care providers. A covered health care provider that has a direct treatment relationship with an individual must:*

(I) *Provide the notice no later than the date of the first service delivery, including service delivered electronically to such individual after the compliance date for the covered health care provider*

(II) *If the covered health care provider maintains a physical service delivery site:*

(A) *Have the notice available at the service delivery site for individuals to request to take with them, and*

(B) *Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered health care provider to be able to read the notice, and*

(III) *Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements of paragraph ©(2)(II) of this section, if applicable.*

Page 82820 Federal Register /Vol.65, No. 250/ Thursday, December 28, 2000/Rules and Regulations.

PATIENT ACKNOWLEDGEMENT: I acknowledge that I have reviewed and received a copy of the Fremont County Department of Public Health & Environment Notice of Privacy Practices as required by the Health Information Portability and Accountability Act. I understand that upon completion of reading this notice, any questions I may have may be addressed to the Fremont County Public Health HIPAA Compliance Officer.

Patient Name: _____

Patient/ Legal Representative Signature: _____ Date: _____

Patient has the right to refuse to Sign this Notice of Privacy. Witness to Refusal Signature _____

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Immunization Consent Form (Internal)

I have been given a copy and have read the information in the Vaccine Information Sheet for each vaccine checked below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of each vaccine requested and ask that the vaccine(s) checked below be given to me or to my child, _____Name of Minor Child_____, for whom I am authorized to make this request.

- ☐ Hepatitis B (HBV, HEP B)
- ☐ Hepatitis A (Hep A)
- ☐ Haemophilus Influenzae b (Hib)
- ☐ Inactivated Polio Virus (IPV)
- ☐ Pneumoncoccal Conjugate (PCV)
- ☐ Measels/Mumps/Rubella (MMR)
- ☐ Meningococcal Conjugate (MCV)
- ☐ Rotovirus
- ☐ Diptheria/Tetanus/Acellular Pertussis (Dtap)
- ☐ Diptheria/Tetanus (DT pediatric)
- ☐ Tetanus/Diptheria/Acellular Pertussis (Tdap)
- ☐ Tetanus/Diptheria (Td adult)
- ☐ Human Papillomavirus (HPV)
- ☐ Varicella (VAR)
- ☐ Inactivated Influenza (Flu)
- ☐ Other _____

_____ _____ _____
Signature of Patient/Parent/Legal Guardian Printed Name/Relationship Date

** A consent must be signed in order for a patient to receive an immunization. For children under 18 the consent will be signed by the parent or legal guardian.*

FCDPHE Office Use Only

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Nurse Administering Signature _____ Date _____

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Immunization Screening Questionnaire

Patient Name: _____ Date of Birth: _____/_____/_____

The following questions are required and are used to help us determine which vaccines may be given today. Please circle your response to each question asked. If you answer "yes" to any question, it does not necessarily the patient 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 patient ill today or have a fever?	Yes / No
2.	Has the patient ever had a serious reaction after receiving a vaccine?	Yes / No
3.	If the patient is a child 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes / No / NA
4.	If the patient is a baby, have you ever been told he or she has had intussusception?	Yes / No / NA
5.	Does the patient have an allergy to any medication, latex or a vaccine component?	Yes / No If yes: _____
6.	Does the patient have an allergy to food, egg or egg product?	Yes / No If yes: _____
7.	Does the patient have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes / No If yes: _____
8.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes / No If yes: _____
9.	In the past 3 months, have the patient taken medications that affect the 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?	Yes / No If yes: _____
10.	During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes / No If yes: _____
11.	Has the patient had a seizure or a brain or other nervous system problem?	Yes / No If yes: _____
12.	Has the patient ever had Guillain-Bare Syndrome?	Yes / No
13.	Is the patient pregnant or is there a chance she could become pregnant during the next 4 weeks?	Yes / No / NA
14.	Has the patient received any vaccinations in the past 4 weeks?	Yes / No

The following puts patients at higher risk for contracting Hepatitis A:

- Traveling to countries that have high rates of Hepatitis A
- Men who have sexual contact with other men
- People who live with or have sexual contact with someone who has Hepatitis A
- Users of injection or non-injection illegal drugs
- People who have chronic liver disease
- People who are treated with clotting-factor concentrates
- People who work with Hepatitis A infected animals or in a Hepatitis A research laboratory

By signing below, I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.

Patient/Legal Guardian Signature: _____ Date: _____

FCDPHE OFFICE USE ONLY

Form Reviewed by: _____ Date: _____