

Welcome Hodgeman County Health Department

Patient's Information:

Name _____
Parent _____
Street Address & P.O. Box # _____

Phone _____
Date of Birth _____
Social Security # _____
Insured's Name _____
Insured's Date of Birth _____
Name of Insurance Company _____
Insured's Policy # _____
Insured's Employer _____

Eligibility Status	
(Complete by Health Department Staff)	
<input type="checkbox"/> VFC	<input type="checkbox"/> Medicaid <input type="checkbox"/> Healthwave <input type="checkbox"/> Alaskan/American Indian Native <input type="checkbox"/> No Health Insurance
<input type="checkbox"/> Under-Insured	<i>Insurance Company does not pay for some or all vaccines</i>
<input type="checkbox"/> Under-Served	<i>Has a high deductible & is WIC income eligible (show WIC income guidelines - no proof required)</i>
<input type="checkbox"/> Insured	<i>Insurance pays first dollar or has low deductible</i>

Notice of Privacy Practices:

I acknowledge that I have received a copy of the Hodgeman County Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.

La Afirmación de Haber Recibido El Aviso Sobre Las Prácticas de Privacidad

Yo reconozco que he una copia del aviso sobre las prácticas de privacidad del departamento de salud con fecha de efectividad 14 de abril, 2003.

Authorization for the Hodgeman County Health Department to Bill Insurance:

I authorize the release of medical information necessary to process claims / medical reports. I authorize payment of medical benefits to the Hodgeman County Health Dept or supplier named on the claim form.

I understand that the Health Department may bill my insurance and I agree to make payment to the Health Department all insurance reimbursement to me for the vaccines given today.

I understand that if for any reason my insurance company does not pay all or part of the vaccine cost, I will be responsible for paying the bill.

Signature of Client or Guardian
Firma del Paciente/Representante del Paciente

Relationship to Patient
Si la firma es de un representante ¿Cuál es su parentesco con el patients?

Date Fecha

Date assessment taken and employee initials: _____ _____ _____ _____ _____ _____

Original to be maintained in Patient's permanent medical record.