CONSNT

CoxHealth
Regional Services
C.A.R.E. MOBILE REGISTRATION

Name: _____
Age: _____ DOB: ___/___/_____
SSN or ID: _____
(or Patient Sticker Here)

Child's Legal Name: _____ SSN#: _____ Birth Date : ____/____/_____
Sex: ☐ Male ☐ Female Address: _____ City: _____ State: _____ Zip: _____
School: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

FINANCIAL OBLIGATION*

PRIMARY INS: _____ **POLICY HOLDER NAME:** _____
Policy Holder's Employer: _____ Policy Holder SSN#: _____
Group #: _____ Policy/ID #: _____ Policy Holder DOB: ___/___/_____
Patient's Relationship to Policy Holder: ☐ Child ☐ Other (explain) _____

SECONDARY INS: _____ **POLICY HOLDER NAME:** _____
Policy Holder's Employer: _____ Policy Holder SSN#: _____
Group #: _____ Policy/ID #: _____ Policy Holder DOB: ___/___/_____
Patient's Relationship to Policy Holder: ☐ Child ☐ Other (explain) _____

☐ **NO INSURANCE** (SELF PAY) **STUDENT QUALIFIES FOR FREE OR REDUCED LUNCH?** ☐ **Yes** ☐ **No**

** The mission of the C.A.R.E. Mobile program is to provide access to health care for children in the Ozarks who have no insurance, do not have a primary care physician or whose parents cannot afford to pay for necessary services. However, no child will be turned away.*

PARENT OR GUARDIAN and EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Phone: _____ Relationship: _____
RELATIONSHIP: ☐ Father ☐ Mother ☐ Guardian
Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: ___/___/_____
Address: _____ City/State/Zip: _____ Home Phone: _____
Employer: _____ Work Phone: _____ Mobile Phone: _____
Preferred method of contact? ☐ Email ☐ Home Phone ☐ Letter ☐ Mobile Phone ☐ Work Phone
RELATIONSHIP: ☐ Father ☐ Mother ☐ Guardian
Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: ___/___/_____
Address: _____ City/State/Zip: _____ Home Phone: _____
Employer: _____ Work Phone: _____ Mobile Phone: _____
Preferred method of contact? ☐ Email ☐ Home Phone ☐ Letter ☐ Mobile Phone ☐ Work Phone

FAMILY HISTORY

Ethnicity: ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander
Patient's biological family has a history of:

☐ Stroke	☐ Heart disease or heart attack	☐ Diabetes/sugar disease	☐ High blood pressure
☐ High cholesterol	☐ Diabetes/sugar disease	☐ Asthma	☐ Hearing loss at young age
☐ Vision loss at young age	☐ Alzheimer's disease/dementia	☐ Developmental delay/retardation	☐ Miscarriage/stillbirth
☐ Breast cancer	☐ Ovarian cancer	☐ Endometrial (uterine) cancer	☐ Colon cancer
☐ Birth Defects	☐ Genetic conditions: _____		

☐ Other Cancer(s): _____
☐ Genetic Conditions: _____
☐ Mental Health: _____
☐ Other Health Concerns: _____

Identify family members with each condition checked:

Relationship	Condition	Age of Onset	Current Age	Age and Cause of Death
Example: Grandmother on Father's Side	*High Blood Pressure*	*61*		*87, Stroke*

CONTINUED ON BACK

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Name: _____
Age: _____ DOB: __/__/____
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(or Patient Sticker Here)

CONTINUED FROM FRONT

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

For parents/guardians: The following questions will help us determine which vaccines your child may be given. 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 medications, food, a vaccine component, or latex?	☐ 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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	☐ Yes	☐ No	☐ Don't Know
Is he/she on long-term aspirin therapy?	☐ Yes	☐ No	☐ Don't Know
5. 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
6. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐ Yes	☐ No	☐ Don't Know
7. In the past 3 months, has the child 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 had radiation treatments?	☐ Yes	☐ No	☐ Don't Know
8. 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
9. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes	☐ No	☐ Don't Know
10. Has the child received vaccinations in the past 4 weeks?	☐ Yes	☐ No	☐ Don't Know

Please send your child's immunization record card with them on the day of their visit to the C.A.R.E Mobile.

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter daycare or school, for employment, or for international travel.

VACCINE RECORD (FOR C.A.R.E. MOBILE USE ONLY)

Vaccines for Children (VFC) Program Eligibility Status: ☐ Medicaid ☐ No health insurance ☐ American Indian/Alaska Native ☐ Underinsured (FQHC/RHC) Diphtheria, Tetanus ☐ NOT VFC Eligible

Vaccine	Route	M/D/Y Given	Injection Site	Manufacturer	Lot Number	Exp. Date	NDC Number	VIS Rev. Date	Date VIS Given
Ex.: Hib	*IM*	*01/01/18*	*Left Arm*	*Sanofi Pasteur*	*AA123AA*	*01/01/18*	*49281-547-58*	*01/01/18*	*01/01/18*

Comments: _____

_____

_____ _____ _____
Vaccinator Signature Vaccinator Title Date

AUTHOR

CoxHealth
Regional Services
C.A.R.E. MOBILE AUTHORIZATION

Name: _____
Age: _____ DOB: ___/___/_____
SSN or ID: _____
(or Patient Sticker Here)

Child's Legal Name: _____ SSN#: _____ Birth Date : ____/____/_____

Sex: ☐ Male ☐ Female Address: _____ City: _____ State: _____ Zip: _____

School: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

This Authorization, Financial Obligation ,Consent and Permission to Share form applies to the CoxHealth C.A.R.E. Mobile (hereinafter referred to as "CoxHealth").

Authorization to Release Information. The Notice of Privacy Practices sets forth rights regarding my child's personal health information and the manner in which it may be used or disclosed. This includes the sharing and/or receiving of prescription information with a prescription database utilized in electronically prescribing medications for my child's treatment, including the review and access to prescriptions prescribed to my child outside of the CoxHealth system. I understand that I have the following rights, among others, regarding my child's information: to receive the Notice of Privacy Practices prior to signing this form; to object to the use of my child's personal health information in any facility directory; and to revoke this form in writing, except to the extent that CoxHealth has already taken action in reliance on this form. I authorize the review, copying, release and disclosure of any and all information in my child's medical or accounting record(s), including information regarding the diagnosis or treatment of HIV, AIDS, mental illness or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment, continuity of care or other matters related to the treatment or services rendered to me by CoxHealth.

Assignment of Benefits. I assign to CoxHealth the benefits otherwise payable to me for any treatment from my insurance carrier or company, managed care plan, health maintenance organization, self-insured health plan, Medicaid or Medicare and its intermediaries and carriers.

Medicaid Beneficiaries. I authorize CoxHealth to obtain information from Missouri HealthNet or other government agencies regarding my entitlement to benefits and my health insurance claim numbers.

Financial Obligation. I understand that I am financially responsible for payment of all amounts due for services provided by CoxHealth regardless of whether I have insurance coverage or whether other parties may also be responsible for paying for my child's care. I will not be responsible to pay for such services rendered if my financial obligation is waived by contractual agreement or prohibited by applicable state or federal laws or regulations. I understand that, as a courtesy to me, CoxHealth will submit claims for third-party coverage to my disclosed insurance carriers and that CoxHealth is authorized to complete any forms which are needed in order to obtain payment from said third-party payers. For all past due accounts, I agree to pay interest at the legal rate if the amount for which I am responsible is not paid within thirty (30) days of receipt of the bill. As part of the collections process, I authorize CoxHealth and any of its agents attempting to collect an unpaid account balance to contact me at any telephone number or address I have provided to CoxHealth using any manner, including the use of an auto-dialing device, at any time until my debts are paid in full. I understand that the cost of collections on past due accounts, including reasonable attorney's fees and court costs, will be included as part of my financial obligation. This agreement shall be governed by Missouri law. I hereby agree venue shall be appropriate in Greene County, Missouri. I also understand, pursuant to the Missouri hospital lien statutes, that if my injuries were caused by the negligence or wrongful act of another, CoxHealth may have a lien on any and all claims or rights of action I may have against the person causing my injuries and CoxHealth may have the right to enforce the lien for payment of services rendered rather than seek payment from any third-party payer.

Consent for Treatment. I agree, request and authorize the school listed above to facilitate treatment and health care for my child that is to be provided by the CoxHealth C.A.R.E. Mobile program, including but not limited to: primary care services, immunizations, vision services, sports pre-participation physicals, and the treatment of common illnesses. I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for any the vaccine(s) my child will receive from CoxHealth. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to my child. I am authorized pursuant to Section 431.058 RSMo to make this request. I realize that among those who attend to patients at CoxHealth are medical, nursing and other healthcare personnel in training who may be present and participating in my child's care as part of their education. I also understand that CoxHealth utilizes the services of Non-Physician Practitioners, that my child may be evaluated and treated by one of these Non-Physician Practitioners and that I have the right to see that provider's collaborating physician. I authorize the taking of photographs, videos or other images of parts of my child's body for use in medical evaluation, education and security purposes. I am aware that the practice of medicine is not an exact science and I understand that no promise, guarantee or warranty has been made regarding the results of the examination or treatment my child receives.

Permission to Share Information. I understand that protected health information (PHI) may include records relating to psychiatric or psychological care; communicable diseases; HIV/AIDS diagnosis or treatment; alcohol or drug abuse treatment; sexually transmitted diseases; and other sensitive information.

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

___ I authorize the release of financial and PHI from the entire CoxHealth system and its Affiliated Covered Entities.

___ I DO NOT authorize the release of financial and PHI from the following entity(s): _____

- In the case of an emergency situation CoxHealth may determine that a limited disclosure may be in my child's best interests and I realize CoxHealth may share limited PHI or other information with those who may be involved in my child's care.
- I relize this form does NOT authorize the person(s) below to make health care decisions for my child or to view or receive copies of my child's medical records.

			Type of Information			
Name:	Phone Number:	Relationship to patient:	All	Scheduling / Appointment	Medical	Insurance / Billing

This covers the following time frames. If NOT marked, all past present, and future encounters are the default.

___ All past, present, and future encounters/visits -OR- Other: _____

Time Limit and Right to Revoke. Except to the extent that action has already been taken in reliance on this authorization, I have the right to revoke this authorization at any time. Unless otherwise revoked, this authorization shall terminate one (1) year from the date signed.

Signature of Parent or Legal Guardian _____ Date _____ Signature of Witness _____ Date _____

(If unable to sign, Representative name ansd Relationship)