

DENTON COUNTY HEALTH DEPARTMENT  
535 S. LOOP 288 STE 1003  
DENTON, TX 76205  
940-349-2900/ FAX 940-349-2901

DATE: \_\_\_\_\_

PATIENT'S INFORMATION:

SS#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

MALE  FEMALE DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ RACE: \_\_\_\_\_

RESIDENCY:  US CITIZEN  RESIDENT ALIEN  UNDOCUMENTED

ADDRESS \_\_\_\_\_ APT/LOT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HM PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

LANGUAGE:  ENGLISH  SPANISH

MEDICAID# \_\_\_\_\_ CHIP # \_\_\_\_\_

RESPONSIBLE ADULT IF MINOR UNDER 18: \_\_\_\_\_ DOB: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_



GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Denton County Health Department (Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient's Name Patient's Signature
Person Authorized to Consent (if not patient) Relationship
Signature Date

I decline HIV testing at this time. If so, initial here:

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name N/A
Name of Person Giving Consent N/A Signature N/A
Relationship to Patient N/A Date N/A
Address N/A
Phone Number N/A

SIGNATURES SECTION III:

Counselor Signature Date

Beginning January 1, 2014 you will be required to bring all your medications with you to each appointment. Medications include: all prescriptions written by a physician, all over the counter non-prescription medications, vitamins, and supplements. If you do not bring your medications with you, you will be asked to reschedule your appointment.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Empezando Enero 1, 2014 todos los pacientes seran requeridos a traer todos sus medicamentos a sus citas. Los medicamentos incluyen: todas las recetas medicas escritas por un medico, todas las medicinas compradas sin receta medica, vitaminas y suplementos. Si usted no trae los medicamentos, su cita sera programada para otro dia.

\_\_\_\_\_  
Firma del paciente

\_\_\_\_\_  
Fecha

Nov. 2013



**III. EXPIRATION & REVOCATION**

**A. This Authorization will Expire (must choose one):**

- 12 months from the date signed
- other (insert date or event): \_\_\_\_\_

**B. Right to Revoke**

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

**IV. ACKNOWLEDGMENTS & SIGNATURES**

**A. Acknowledgments**

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request.
4. I authorize the Denton County Health Department to access past RX (prescription) history.

X \_\_\_\_\_  
**Signature of Individual or Individual's Legally Authorized Representative      DATE**

**Printed Name**

**If representative, specify relationship to the individual:**  Parent of minor  Guardian  
 Other \_\_\_\_\_

X \_\_\_\_\_  
**Name & Relationship of Individual Who Helped You Fill Out this Form (if applicable)**

A minor individual's signature is required for the release of certain types of information, including the release of information related to certain types of reproductive care, sexually transmitted illnesses, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

X \_\_\_\_\_  
**Signature of Minor Individual**

The following information is for administrative purposes and may only be completed by an entity that is a "Program" under 42 C.F. R. Part 2 with respect to alcohol and drug abuse records.

If checked - disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C. F.R. Part 2:  
 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# Immunization Patient Eligibility Screening Record: Adult

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the information below is true and correct.



Name: \_\_\_\_\_  
 Last Name First Name

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 month day year

Please check the category that applies. Then, sign and date on the right.

I have Medicaid	I have private health insurance	I have NO health insurance	I have Medicare	Signature	Date	Verified by (staff initials)	Clerical Staff Use Only: Program Eligibility		
							AIP	ASN	Private

Please circle family size:

1	2	3	4	5	6	7+
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Please circle monthly income:

\$0-1,772	\$1,772.01-1,915.00	\$2,392.01-2,585.00	\$3,011.01-3,255.00	\$3,631.01-3,925.00	\$4,251.01-4,595.00	\$4,871.01+
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MEDICAID:  
 Medicaid number: \_\_\_\_\_  
 Date of eligibility: \_\_\_\_\_

Check here if you are 19 years of age and have been referred to the Denton County Health Department to finish a vaccine series you began when you were 18 or younger and eligible for Texas Vaccines for Children (TVFC).

Referring Provider: \_\_\_\_\_

