CLINIC REGISTRATION FORM

www.scphoh.org
1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: 330-752-7925

Date:_____

Reason for Visit:
☐Received a post card ☐Received a phone call ☐New patient ☐Return visit

How did you hear about us: _____

Patient Information:
Last Name:_____ First Name: _____Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: ( )_____ E-Mail Address: _____
Are you currently homeless, residing in a shelter, or currently have no fixed address? ☐Yes ☐No
Date of Birth: ____/____/_____ Age:_____ ☐Male ☐Female Social Security Number:_____-____-_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Mark all that apply: ☐ African American ☐ Caucasian ☐Asian ☐Hispanic ☐American Indian/Alaskan Native ☐Other_____
In Case of Emergency, who should be notified? _____
Phone: ( ) _____ Relationship: _____
Doctor's Name: _____ Phone number: _____

Insurance information
☐ I have insurance coverage
☐ I have no insurance coverage
Does your insurance cover immunizations? ☐Yes ☐ No
Would you like a Medicaid application? ☐ Yes ☐ No

Primary Insurance Coverage
Name and Address of insurance company _____ Effective date____/____/_____
Name of person on card _____ SS #_____-_____-_____ Birth date____/____/_____
ID # on card _____ Group # on card _____

Secondary Insurance Coverage
Name and Address of insurance company _____ Effective date____/____/_____
Name of person on card _____SS #_____-_____-_____ Birth date____/____/____
ID # on card _____ Group # on card _____

I understand that the charges for today's visit will be submitted to my insurance company for payment and that any balance not paid for by my insurance is my responsibility to pay. Initial_____

☐ Please check this box if you would like information about other resources or programs offered in our community. (If you have specific needs for your family, you may list them below and a nurse will be happy to help you when you are seen)

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

_____

Client or Guardian Signature **Date**

SUMMIT COUNTY PUBLIC HEALTH
1867 West Market Street ◆ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ◆ Toll-free: 1 (877) 687-0002 ◆ Fax: (330) 752-7925
www.scphoh.org

PATIENT CONTACT DIRECTIVES

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____/_____/_____ Phone Number (Home/Cell)_____ Language:_____

Patient Privacy Directives
In our efforts to comply with the health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Do we have permission to:
Contact you on the number listed above to discuss appointments, treatment or test results?
☐Yes ☐No

Leave a message regarding appointments on the number listed above?
☐Yes ☐No

Would you like us to text health information to you? (Encoded STD test results only)
☐Yes ☐No

*Would you like us to share health or payment information with close friends or relatives, directly involved with your care?
☐Yes ☐No

If yes:

*Please provide us with a name and phone number that we may leave messages regarding **appointments**:
Name:_____Number:_____(Home/Cell//Email)

Relationship to Patient _____

*Please provide us with a name and phone number that we may leave a message regarding **treatments and/or test results.**
Name:_____Number:_____(Home/Cell/Email)

Relationship to Patient_____

*Do you have any other specific instructions/requests about how we should communicate with you or others about your appointments, treatment, or test results?_____
_____

I acknowledge that all information above is accurate. You must inform us **in writing** of any changes in your directives.

_____ _____ ____/____/_____
Signature Printed Name Date

TB HISTORY FORM

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558

DEMOGRAPHICS

Last name | First Name | MI | D.O.B. | M / F | Age

Address | City | County | State | Zip Code

Telephone _____ Home / _____ Work / _____ Cell Client signature _____

Date _____

SKIN TEST INFORMATION

Reason for this test? School _____ Work _____ Symptoms _____ Other _____

Past TB Skin Test: Yes ____ No ____ If yes, date of test _____ Results _____

Have you received a live vaccine in the last 42 days? Yes_____ No_____

Previous Chest X-Ray? Yes ____ No ____ If yes, date of x-ray _____ Where x-ray done _____

Have you ever been exposed to someone with active TB? Yes ____ No____ If yes, When? _____

To whom were you exposed? _____

Mantoux #1 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

Mantoux #2 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

Criteria for Classifying Positive TST Reactions

Reaction of ≥ 5 mm of induration is considered positive in	**Reaction of ≥ 10 mm of induration is considered positive in**	**Reaction of ≥ 15 mm of induration is considered positive in**
• HIV-infected persons • Recent contacts of infectious TB cases • Persons with fibrotic changes on chest radiograph consistent with prior TB • Organ transplant recipients • Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of > 15 mg/day of prednisone for 1 month or more, taking TNF-a antagonist	• Recent immigrants (within last 5 years) from a high-prevalence countries) • Injection drug users • Residents of employees of high risk congregate settings • Mycobacteriology laboratory personnel • Children< 4 years of age, or children or adolescents exposed to adults at high risk • Persons with clinical conditions previously mentioned	• Persons with no known risk factors for TB* *Although skin testing programs should be conducted only among high risk groups, certain individuals may require TST for employment or school attendance. An approach independent of risk assessment is not recommended by CDC or the American Thoracic Society.

If TST is 5 mm or greater, complete sections A and B

Section A: Symptom Review

Date of Interview: _____ Nurse Conducting Interview _____

Check appropriate answer

	Yes	No	Comments
Fever			
Chills			
Night Sweats			
Cough			If yes, how long has cough occurred: Is there sputum production: Is there hemoptysis:
Shortness of Breath			
Loss of appetite			
Unexplained weight loss			If yes, number of pounds in number of weeks:
Chest pain			
Smoker			

Section B Risk Factors

Check appropriate answer

	Yes	No	Comments
Contact to active TB case?			
Foreign born			
HIV positive			
Injectable drug use			
Organ transplant			
Homeless			
Diabetes			
Prolonged steroid or immunosuppressive drug use			
Silicosis			
Works in high risk facility			
Lives in high risk facility			
Chest or abdominal surgeries			

Based on symptoms, does patient need to be evaluated for acute TB infections? Yes ____ No ____

Based on risk factors, does patient meet criteria for a positive TST? Yes ____ No ____

Disposition

_____ No referral needed; does not meet criteria for positive test

_____ Refer to private physician for evaluation of TB/LTBI
Private physician name: _____

_____ Local health department for evaluation of TB/LTBI
Chest x-ray ordered: Yes ____ No ____
Physician evaluation: Yes ____ No ____

Summit County Public Health
1867 W. Market St. • Akron, OH 44313 • 330-923-4891

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Compliance With Other Laws

Other provisions of law may apply to your information. If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records are subject to the following restrictions:

- Information regarding participation in a treatment program or identifying a patient as a substance abuser will not be disclosed except as permitted by applicable law.

- Disclosures, other than those explicitly required by 42 CFR Part 2, require consent in writing from the patient unless the patient is incompetent, the patient condition prevents knowing or effective action, or the patient is deceased. We may not release the records of minors without the consent of the minor, except as required by law.
- Disclosures by court order require both a court order and a subpoena.
- Disclosures may be made for scientific research, program evaluations or audits, and emergencies.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 5/15/2017

For questions, please contact the Summit County Public Health Privacy Officer by calling 330-923-4891.