TERRENCE J. REIDY
HEALTH OFFICER

GINO E . SISCO
ADMINISTRATOR


1948 WILTSHIRE ROAD, SUITE 1
KEARNEYSVILLE, WV, 25430
PHONE: 304-728-8416
FAX: 304-728-3319
WWW.JCHDWV.ORG

## PATIENT INFORMATION

**Patient's Name** _____ _____ _____
(Last) (First) (Middle Initial)

**Mailing Address** _____

**City**_____**State** _____**Zip** _____

**Date of Birth** _____ **Age** _____ **Gender** _____ **SS#** _____ **Race** _____
Month/Day/Year Male/Female (optional)

**Home Phone #** _____ **Cell Phone #**_____ **Work Phone #**_____

## EMERGENCY CONTACT

**Contact Name** _____ **Phone Number** _____

Initial here for permission to discuss case with the person named above: _____

## ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The Jefferson County Health Department (JCHD) Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of this notice is available upon request. By signing this form, you acknowledge that the JCHD Notice of Privacy Practices was made available to you.

I give permission for JCHD to share information about services rendered here with the following person, people, or organization(s):

_____

_____ _____
**Patient/Patient Representative's Signature** **Date**

## PAYMENT INFORMATION

☐ **Option 1: Self-pay -** Cash, check, or credit card payments are accepted. Payment plans are available for those unable to pay in full. The first payment is due on the date of service and the remaining payments will be due within a six month period.

☐ **Option 2: Bill Insurance – TURN OVER AND COMPLETE REVERSE SIDE**

☐ **Option 3: VFC –** Routine immunizations for uninsured and underinsured patients 18 and under are covered by the Vaccines for Children Program.

☐ **Option 4: Bill Employer or other organization – COMPLETE SEPARATE BILLING CONSENT FORM**

**Health Department Use Only – Patient Payment**

**Amount $**_____ **Cash** **Credit** **Check #**_____

**Receipt/Invoice #**_____ **Payment Plan**_____

**Staff Signature** _____

# THIS PAGE MUST BE COMPLETED TO BILL INSURANCE

## Health Insurance Information

**PRIMARY INSURANCE:** ☐ None

Insurance Company Name: _____ Plan name: _____

ID Number: _____ Group Number (if any): _____

Policy Holder: _____ _____ _____ _____
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____ Relationship to Patient _____ SS # _____

Policy Holder Address (if different from patient): _____

Home Phone# _____ Cell Phone # _____ Work Phone # _____

**SECONDARY INSURANCE:** ☐ None

Insurance Company Name: _____ Plan name: _____

ID Number: _____ Group Number (if any): _____

Policy Holder: _____ _____ _____ _____
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____ Relationship to Patient _____ SS # _____

Policy Holder Address (if different from patient): _____

Home Phone# _____ Cell Phone # _____ Work Phone # _____

Initial ↓

## BILLING CONSENT

_____ I authorize Jefferson County Health Department (JCHD) to bill my health insurance company for services provided by the Department, and to exchange information necessary to secure payment for services rendered. Such necessary information may include diagnosis, service dates, types of services and other information related to JCHD's services necessary to process claims. I further authorize JCHD to release information for purposes of fee collection.

_____ I will notify JCHD of any changes in my health insurance coverage as well as any denial information.

_____ I understand that if an insurance payment is made directly to me I am responsible for immediately sending any such payments to JCHD.

_____ I understand that submission of insurance information does not guarantee coverage. It is the policy holder's responsibility to know their coverage plan.

_____ I understand that if the insurance company does not cover the services, I will be responsible for all payments for services rendered.

_____ _____
**Patient/Patient Representative's Signature** **Date**

_____ _____
**JCHD Staff Member Signature** **Date**