Jackson County Schools Wellness Center

562 Charleston Drive
Ripley, WV 25271
Phone: (304) 372-7341
Fax: (304) 372-3272

Last Name _____ First Name _____ MI___
Social Security _____ Date of Birth _____
Mailing Address_____
City _____ State _____ Zip Code_____ County_____
Home Phone (_____) _____ Cell Phone (_____) _____

Usual Pharmacy (include location) _____
(Please provide the receptionist with your prescription card for copying if it is not included on your medical insurance card)

Gender: Male Female **Marital Status**: M____ S ____ Other _____
Name of Spouse/Guardian: _____ SS# (if patient is under 18) _____
Email Address:_____
Is the patient a Veteran? Yes____ No____

Employed: Yes____ No____ **Retired:** Yes____ No____ **Disabled:** Yes____ No____
Employer _____ Phone _____
Employers Address _____
Student: Full Time____ Part Time____ Name of School_____

Responsible Party _____ Relationship_____
Mailing Address _____
City _____ State _____ Zip Code_____
Home Phone (____) _____ Cell Phone (____) _____

Emergency Contact (list different than above number)
Name: _____ Relationship _____
Phone (____) _____ May we leave a message? Yes____ No____
Comments_____

Race/Ethnic Identity: Please note that this information is voluntary and you are not required to answer this question. No patient will be discriminated against because of race, gender, color, natural origin, age, or disability.
___ Asian ___ Black ___ Caucasian ___ Hispanic (all races) ___ American Indian
___ Native Hawaiian ___ Pacific Islander ___ Unreported/Unknown ___ Other _____

INCOME INFORMATION – Please complete all that apply.

Please Circle the Following:
How many people are currently living in your household? 1 2 3 4 5 6 7 8 9
What is your estimated household monthly net income?

$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000

$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

INSURANCE INFORMATION – Please complete all that apply

If you do not have insurance, please check here_____

Would anyone in the household be interested in receiving an application for our sliding fee program or medication assistance program? ____ Yes ____ No

Household Status: ___ own my home ___ rent ___ live with someone else ___ in shelter

- **Primary Health Insurance:**
  Name of Insurance Company _____
  Group # _____ ID# _____
  Insurance Address _____
  Insurance Phone _____ Fax _____
  Name of Insured Parent / Guardian_____
  Birth date of Card Holder_____ SSN of Card Holder _____
  Address (if different from child) _____
  Place of Employment _____

- **Secondary Health Insurance**:
  Name of Insurance Company _____
  Group # _____ ID# _____
  Insurance Address _____
  Insurance Phone _____ Fax _____
  Name of Insured Parent / Guardian_____
  Birth date of Card Holder_____ SSN of Card Holder _____
  Address (if different from child) _____
  Place of Employment _____

The following information is to be completed by the patient

I consent to medical treatment for myself. I understand that Coplin Health Systems (CHS) will share patient health information according to federal and state law for treatment, payment, and healthcare operations.

I understand that the patient is responsible for any co-pays or balances on this account. As a courtesy, CHS will submit claims to my insurance.

I authorize the insurance provider to pay for services rendered.

I understand there is a $25.00 fee for all returned checks.

Signature of patient: _____ Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information.

Please note there is an attached copy of HIPAA to this consent form, for the parent/guardian of the student receiving medical, dental or behavioral health counseling services at Jackson County Schools Wellness Center. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services.

I certify that I have received a copy of Jackson County Schools Wellness Center's Notice of Privacy Practices (HIPAA). The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Jackson County Schools Wellness Center's health care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative Authority
(Relationship)

_____ _____

Witness Signature Date

By initialing this section, I understand **I am giving my permission for a student (enrolled in a medical or nursing school) to be present during patient care services** provided to me at all centers operated by Coplin Health Systems.

Please initial here if you agree to have a student present during our care: _____