Your child may not receive the flu vaccine today if....
***they are not a patient here at Partners in Pediatrics**

COVID-19 SCREENED OK Employee initials _____

Clinic Questionnaire

Patient Name: _____

DOB___/___/___ Age: ____

1. **YES NO Has your child been seen in this office by one of our physicians?**
2. **YES NO Child is a patient of our practice.**
3. YES NO Has child had a fever within past 24 hours or illness at present? If yes, CANNOT RECEIVE TODAY.

If Child is 6 months to 8 years old please answer following question.

4. YES NO NOT SURE Has your child received a total of 2 or more doses of Influenza vaccine in the past?

* Unless Yes to question 4 child receives 2 doses.

Doses should be administered a minimum of 4 weeks apart.

If child is 9 years or older administer 1 dose.

Parent Consent: _____ Date:___/___/_____

Office Use Only

Site	Lot #	Exp date	Manufacturer	MA signature
___	_____	___/___/___	_____	_____

REVISED 8/2020

University Hospitals

Patient _____ _____ _____ _____
Last name First Name Middle Initials Date of Birth

Authorization for Treatment

This is the consent form for you to authorize University Hospitals (UH) to provide Services to the Patient named above. UH performs Services in a variety of settings, including medical centers, doctor's offices, health centers, home care, and hospice. Those who provide the Services may not be physicians. Services may be provided by independent practitioners, including physicians, who are not employees or agents of UH. All of University Hospitals Health System, Inc. locations and providers are called UH in this form. UH is a teaching institution and healthcare personnel in training may be present and participate in providing care. UH is not responsible for the acts or omissions of providers who are not directly controlled by UH. As used in this form, Services are the diagnostic, therapeutic, medical, physician, nursing, technical, and/or surgical services and/or procedures and associated support, including, but not limited to, x-rays, photographs, and laboratory testing necessary for care and quality assurance. Services may be provided through telehealth, utilizing technology to connect me and/or data about me to providers who may not be in the same physical location. Except in some circumstances, such as an emergency, any Services will be performed after I have been informed of the benefits and material risks associated with such Services and I have given my verbal consent. I understand that the Services do not guarantee a specific outcome or recovery.

By signing below, I, as or on behalf of the Patient, consent to receive and authorize UH to provide the Services.

Authorization to Access & Release Information

I acknowledge receipt of the University Hospitals Notice of Privacy Practices, which describes how UH may access and/or release all or any part of Patient information (including, but not limited to, information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) for purposes required by State and/or Federal law; in cooperation with a law enforcement investigation; treatment, billing or collecting payment for Services, and/or health care operations, which include improving quality, accreditation, training and education, performance improvement initiatives, discharge planning, risk management, for research-related purposes, population health, including improvement of healthcare delivery and communications, participation in health information exchange(s), including Clinisync, patient registries, organ procurement organizations and clinical collaborations, or as otherwise authorized and for any other permissible purpose. UH retains patient medical records in accordance with applicable law. UH may, unless otherwise refused, photograph and/or audio or video record me or the Services I receive, including those in which I am identifiable. UH will own such images or recordings and may use them for any lawful purpose.

I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with both federal law and regulations. I release the Hospital from any liability that might result from the disclosure of this information. I may revoke this permission at any time.

Assignment of Benefits & Payment

I assign to UH, all benefits for all Services received or to be received. I direct the Patient's insurer(s) and other third parties to pay such benefits directly to UH and/or my physician(s). I hereby agree to pay any and all UH or affiliated provider fees that exceed or that are not covered by insurance coverage, including for Services deemed to be experimental or investigational, and waive any and all notices and demands in the event of non-payment. Subject to any applicable UH financial assistance policy, I understand and agree to pay the charges incurred by the Patient, including for personal use and/or convenience items, and hereby authorize the hospital to bill me or any other applicable party for such use. I authorize UH to pursue payment for services and appeal the denial of payment for services, on my behalf.

Medicare/TRICARE/Champus Payment

I certify that the information I gave is correct. I authorize any holder of medical or other information about the Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for professional services to the provider furnishing these services or authorize such provider to submit a claim to Medicare for payment to me.

By signing this form, I acknowledge, as applicable:

For Medicare and/or Champus/Tricare beneficiaries, I have been provided with an unaltered copy of the notice from Medicare and/or Champus/Tricare regarding my rights as a Medicare and/or Champus/Tricare patient.

Authorization to Contact

I authorize UH, any of its affiliated providers, to contact me for any purpose by any means I have provided, including telephone, voicemail, text message, email, or similar communication methods, including to remind me about upcoming appointments, to provide information related to those appointments (e.g., cancellations), or to provide other educational information related to my care, including eligibility to participate in research studies. I acknowledge that these communications or messages may contain protected health information.

I consent to receive text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from UH and its business associates, including billing services, collection agencies, or other third parties for any purpose. I understand this consent to communications is not required to receive Services from UH and that data usage and other charges may apply.

I may revoke this consent to any or all of these communications at any time.

Patient Personal Property

I understand that UH is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except to the extent UH has already acted in reliance on this form. I **UNDERSTAND THAT CHANGES OR ALTERATIONS TO THIS FORM ARE NOT BINDING ON UH AND REFUSAL TO SIGN MEANS I MAY NOT RECEIVE SERVICES.**

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

Printed Patient Name	Hospital No.
Signature of Patient	Date / Time
Signature of Legal Representative, if patient is unavailable	Relationship / Date
Time	
Witness	Date / Time

UNIVERSITY HOSPITALS MEDICAL PRACTICES

Patient Registration Form

PATIENT INFORMATION Today's Date _____

Last Name_____ First Name_____ MI_____

Address_____City_____State_____Zip_____

Phone: _____ Sex: M or F **Birthdate**_____

Register other children	**Birthdate**	**Sex: F/M**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mother/Guardian Name_____
Date of Birth_____
Address_____
City_____**State**_____
Zip Code:_____ **SS#:**_____
Home Telephone_____
Cell /Pager#:_____
Employer Name:_____
Work #:_____**Ext.:**_____

Father/Guardian Name_____
Date of Birth:_____
Address:_____
City:_____**State:**_____
Zip Code:_____ **SS#:**_____
Home Telephone:_____
Cell/Pager#:_____
Employer Name:_____
Work #:_____**Ext.:**_____

RESPONSIBLE PARTY/ GUARANTOR INFORMATION ***(To whom statements are sent)***

(The responsible party/guarantor will get the bill and is responsible for payment- patients 18 or older will automatically be setup as their own unless authorized by signature below)

Last Name_____ MI_____ First Name_____

Relationship to Patient *(circle):* Self Spouse Father Mother Guardian Other _____

I authorize the above "Guarantor" to receive my medical bills:

X Signature _____

PHARMACY INFORMATION:

Name:_____

Location/City:_____

Phone:_____

UNIVERSITY HOSPITALS MEDICAL PRACTICES

Patient Registration Form

INSURANCE & POLICY - HOLDER INFORMATION

Primary Insurance Company Name_____

Member ID # _____ Group # _____

Effective Date: _____

Policy Holder Name_____ **Date of Birth** _____

Relationship to Patient (circle): Self Spouse Father Mother Guardian Other_____

Employer (required): _____

Secondary Insurance Company Name_____

Member ID # _____ Group # _____

Effective Date: _____

Policy Holder Name_____ **Date of Birth** _____

Relationship to Patient (circle): Self Spouse Father Mother Guardian Other_____

Employer (required): _____

PHYSICIAN INFORMATION **Primary** Doctor's Name _____

List all doctors this patient has seen in the last 3 years – please estimate the month / year last seen

Doctor	Month/Year	Doctor	Month/Year
1_____	_____	1_____	_____
2_____	_____	2_____	_____

OTHER IMPORTANT INFORMATION

How did you hear about us?

_____

May we leave a phone message with an appointment reminder, follow up reminder and/or result of medical tests and/or procedures on your answering machine or voicemail?

Home Phone Yes/No Cell Phone Yes/No Work Phone Yes/No

Primary Language: ☐ English ☐ Spanish

☐ Other (specify): _____

Race: ☐ American Indian ☐ Asian ☐ African American ☐ White

☐ Other (specify):

Ethnicity:

☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Cuban ☐ Dominican

☐ Mexican ☐ Puerto Rican ☐ South American ☐ Spaniard ☐ Central American