Client Name: ____
Date of Birth: __________________
Address, City, Zip: _______________________________________
Phone Number: _________________
Hispanic or Latino/ Non-Hispanic or Latino: (circle one)
Race: _________________________

Acknowledgement/General Consent

1. I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices.
2. I authorize the release of the medical or billing information necessary to process claims for insurance providers including Medicare. I have been informed that if I provide a copy of my Health Insurance or Medicare card, a claim for service will be submitted to my insurance provider. If an insurance claim is denied, services will be billed to me at full charge unless the Income Documentation section has been completed and qualifies me for a reduced rate.
3. I authorize payment of insurance benefits to the Reno County Health Department.
4. I consent to the inclusion of my or my ward’s immunization data in the Kansas Immunization Registry.
5. I consent to my ward's data to be included in a Reno countywide longitudinal study to track kindergarten readiness and the effectiveness of early childhood programs.
6. I consent to receive text messages at the phone number listed in the patient profile and agreed to SMS. I understand that this service can be enabled or disabled at any time per my request.
7. I understand that if health problem areas are identified which need further evaluation, the APRN/nurse will make appropriate referrals.
8. I consent to a health assessment and screening activities by the Reno County Health Department Staff and/or contracting physician as they deem advisable. This may include, but is not limited, to immunizations, TB skin tests, attendant care activities, homemaking, foot care, supervisory visits, medication set up and wellness monitoring.
9. I understand information and records which pertain to the immunization status of persons against childhood diseases as required by K.S.A. 65-508 and 65-519 may be disclosed and exchanged without a parent or guardian's written release authorizing such disclosure to those who need such information. See K.S.A. 65-531 for complete details, a copy of which will be provided to you upon request.
10. I understand that in giving consent to care and treatment herein, I retain the right to refuse any examination or treatment.

I authorize the following person(s) to authorize or consent to the above referenced medical services or the release of medical information on behalf of my child or ward until further notice:

Name ____ Date of birth ______________ Relationship to client _____________________

Name ____ Date of birth ______________ Relationship to client _____________________

Name ____ Date of birth ______________ Relationship to client _____________________

____ ____

Signature of Client, Parent or Guardian Date