Wirt County Schools Wellness Center

#3 Schoolview St, PO Box 400
Elizabeth, WV 26143
Phone: (304) 275-3117
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Wirt County Schools Wellness Center Adult Enrollment Form

Last Name _____ First Name _____ MI_____
Social Security _____ Date of Birth _____
Mailing Address_____
City _____ State _____ Zip Code_____
Home Phone (____)_____ Cell Phone (____)_____
What county do you live in? _____

Gender: Male Female **Marital Status**: M____ S ____ Other _____
Name of Spouse: _____

Is the patient a Veteran? Yes____ No____

Employed: Yes____ No____
Employer _____ Phone _____
Employers Address _____

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 $100 –$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

Responsible Party_____ Relationship_____

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

☐ **Secondary Health Insurance:**
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Name of Insurance Company _____
Insurance Address
_____
_____
Insurance Phone / Fax Number _____
Group & ID Number _____

The following information is to be completed by the patient

I consent to medical treatment for myself. I understand that Wirt County Health Services Association will share patient health information according to federal and state law for treatment, payment, and operations.

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

I authorize the insurance provider to pay WCHS 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

ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPPA) 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 HIPPA to this consent form, for the parent/guardian of the student receiving medical, dental or mental health counseling services at Wirt County Schools Wellness Center. You must sign below, indicating that you have received a copy of our HIPPA policies, prior to the student receiving services.
I certify that I have received a copy of Wirt County Schools Wellness Center's Notice of Privacy Practices (HIPPA). 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 Wirt 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