Coplin Clinic

1301 Elizabeth Pike
Elizabeth, WV 26143
Phone: (304) 275-3301
Fax: (304) 275-4798

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

☐ **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, WCHSA will submit claims to my insurance.

I authorize the insurance provider to pay WCHSA 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 mental health counseling services at Wirt 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 Wirt 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 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

NO SHOW POLICY:

If we are not notified at least 24 hours in advance that you will not be keeping your appointment, your account will be charged $15.00. This cannot be billed to an insurance company, and you will be charged regardless of the type of insurance that you currently have. **This must be paid prior to another appointment being scheduled.**

_____ _____
Signature of Patient or Personal Representative Date