h2u
HEALTH TO YOU

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

General Consent for Laboratory and Diagnostic Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended laboratory or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the laboratory and diagnostic evaluation(s) necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary laboratory and diagnostic testing. By signing below, you are indicating that you consent to laboratory and diagnostic evaluations at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test(s) recommend by your health care provider, we encourage you to ask questions.

I understand that if additional testing, invasive or interventional, is recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

H2U Health Center at _____

Patient Information:

Patient Name: (Last) _____ (First) _____ (MI) _____
Date of Birth (DOB): _____ Sex: ☐ Female ☐Male ☐Transgender
Social Security Number (SS#): _____-_____-_____
Address: _____
City, State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown
Employer Name: _____ Employer Department: _____
Employee ¾ (If applicable)_____ Medicare Enrolled (check): ____Part A ____Part B ____Part D
How did you hear about us:
_____ Website _____ Co-worker _____ New Hire Orientation _____ Newsletter
Other, please describe:_____

Responsible Party/Policy Holder (If Other Than Patient):

Policy Holder's Name: (Last) _____ (First) _____
Policy Holder's Date of Birth (DOB): _____ Insurance Company_____
Policy # _____ Group #_____
Policy Holder's Social Security Number (SS#):_____-_____-_____

Additional Information:

Email Address: _____* **email address is required in order to access the Patient Portal**
Pharmacy Name/Location: _____
Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐Declined
Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐ Other
_____

Emergency Contact Information:

Emergency Contact: (Last) _____ (First) _____
Phone Number: (1) _____ (2) _____
Emergency Contact Relationship to Patient: _____

Current Physician's Names:

Primary Care Provider (PCP): _____
Any Other Physician: _____

I acknowledge that the information provided on this form is accurate and up-to-date to the best of my knowledge. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that a request for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

_____ _____
Patient Signature / Guardian Signature Date

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name**:** _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

h2U HEALTH TO YOU

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

h2U HEALTH TO YOU

Patient History Form

Patient's Name (Last) _____ (First) _____ (MI)_____ Date of Birth MM____/DD____/YYYY____

Medical Problems: Have you had (or do you have) any of the following medical problems: (check Yes or No)

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Breast Cancer	❑	❑	Emphysema	❑	❑	Other Kidney Disease
❑	❑	Heart Disease	❑	❑	Colon Cancer	❑	❑	Tuberculosis	❑	❑	Seizure Disorder
❑	❑	Heart Attack	❑	❑	Other Cancer	❑	❑	Sickle Cell	❑	❑	Rec'd Blood Transfusion
❑	❑	Stroke	❑	❑	Abnormal PAP	❑	❑	Anemia	❑	❑	STD
❑	❑	Diabetes	❑	❑	Hepatitis or Jaundice	❑	❑	Arthritis			
❑	❑	Thyroid Disease	❑	❑	Liver/Pancreas Disease	❑	❑	Kidney Stones			
❑	❑	Positive HIV or AIDS	❑	❑	Asthma	❑	❑	Urinary Tract Infection			

Other (please describe)

_____

_____

Past Surgery: Have you had any of the following operations and year of procedure

❑ Appendix - Year: _____
❑ Hernia - Year: _____
❑ Tonsils - Year: _____
❑ Gall Bladder - Year: _____
❑ Heart - Year: _____
❑ Thyroid - Year: _____
❑ Lung - Year: _____
❑ Hysterectomy - Year: _____
❑ Spine/Joint - Year: _____

Other (please describe)

_____

_____

Patient Social History

Marital Status:	❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widowed
Use of Alcohol:	❑ Never	❑ Rarely	❑ Moderate	❑ Daily	❑ Previously, Quit
Use of Tobacco:	❑ Never	❑ Previously, Quit	❑ Current	❑ Packs Per Day: _____	

Use of Drugs: **YES** ❑ **NO** ❑ Type: _____ Frequency: _____

Family Medical History

	Age	Disease	Deceased/Cause of Death
Father			
Mother			
Sibling			

In the event a procedure needs to be rescheduled, what hospital do you prefer?

_____

Signature: _____ Date: _____

h2u HEALTH TO YOU

Patient Medication List

Name: _____

Date: _____

Medication Allergies:

_____

_____

_____

Prescriptions						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who prescribed it? (Physician's last name)**	**Why do you take it?**	**Do have any side effects? Describe them.**

Over-the-counter medications, herbal remedies, vitamins						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who recommended it?**	**Why do you take it?**	**Do have any side effects? Describe them.**

VACCINE INFORMATION STATEMENT

Influenza Vaccine

What You Need to Know

(Flu Vaccine, Inactivated or Recombinant)
2014-2015

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every winter, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions — such as heart, lung or kidney disease, nervous system disorders, or a weakened immune system. Flu vaccination is especially important for these people, and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine is the best protection against flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Inactivated and recombinant flu vaccines

You are getting an injectable flu vaccine, which is either an "**inactivated**" **or** "**recombinant**" vaccine. These vaccines do not contain any live influenza virus. They are given by injection with a needle, and often called the "flu shot."

A different, **live**, **attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

Flu vaccination is recommended every year. Some children 6 months through 8 years of age might need two doses during one year.

Flu viruses are always changing. Each year's flu vaccine is made to protect against 3 or 4 viruses that are likely to cause disease that year. Flu vaccine cannot prevent all cases of flu, but it is the best defense against the disease.

It takes about 2 weeks for protection to develop after the vaccination, and protection lasts several months to a year.

Some illnesses that are not caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

Some inactivated flu vaccine contains a very small amount of a mercury-based preservative called thimerosal. Studies have shown that thimerosal in vaccines is not harmful, but flu vaccines that do not contain a preservative are available.

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- **If you have any severe, life-threatening allergies**. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, including (for example) an allergy to gelatin, antibiotics, or eggs, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome** (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well**. It is usually okay to get flu vaccine when you have a mild illness, but you might be advised to wait until you feel better. You should come back when you are better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Problems that could happen after any vaccine:

- Brief fainting spells can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Severe shoulder pain and reduced range of motion in the arm where a shot was given can happen, very rarely, after a vaccination.
- Severe allergic reactions from a vaccine are very rare, estimated at less than 1 in a million doses. If one were to occur, it would usually be within a few minutes to a few hours after the vaccination.

Mild problems following inactivated flu vaccine:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Moderate problems following inactivated flu vaccine:

- Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Inactivated flu vaccine does not contain live flu virus, so you cannot **get the flu from this vaccine**.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

CONSENT FORM FOR SEASONAL INFLUENZA VACCINE

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to ME/ MY CHILD. (circle one)

Please print:

Title: _____ Name: _____ 3/4 ID or Last 4 SSN: _____
(FIRST) (MIDDLE) (LAST)

Child's Birthday____/____/____ & Age_____ (if applicable)
Is your child 6 months of age or older? YES/ NO **(If "no," your child may not receive the vaccine at this time.)**

Parent or Guardian's Name: _____

Vaccine is for (circle one): Physician Employee Contractor Volunteer

Family Member (Adult) Family Member (Child) Other_____

Company/Organization: _____

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? ____Yes ____No

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness? ____Yes ____No

Is the person receiving the vaccine pregnant? ____Yes ____No (If yes, LAIV contraindicated, TIV recommended)

Is the person receiving the vaccine allergic to Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? ____Yes ____No

For child 6 mo-8 yrs, have they received 2 or more doses of influenza vaccine since July 2010? ___Yes___No
(If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)

_____ _____
Signature of person receiving vaccine OR Parent/Guardian **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: _____

Lot number: _____Expiration Date: _____CHECK ONE:

___ 0.5 mL IM Influenza Virus Vaccine given in ___left ___right deltoid – TIV or QIV
___ 0.5 mL IM Influenza HIGH Dose Virus Vaccine given in ___left ___right deltoid (65+) TIV-SR
___ 0.2 mL Live Attenuated Influenza Virus Vaccine given intranasally (half each nostril)
___ 0.5mL Intradermal Virus Vaccine site _____ - TIV
___ 0.5mL FluBlok Influenza Virus Vaccine given in ___left ___right deltoid
___ Children 6-35 months: 0.25 mL/dose given in ___left ___right deltoid (1 or 2 doses per season)
___ Children 3-8 years: 0.5 mL/dose given in ___left ___right deltoid (1 or 2 doses per season)
___ Children older than 9 years: 0.5 mL/dose given in ___left ___right deltoid (1 dose per season)

_____ _____ _____
Nurse/ Provider's Signature Date Time

Place Employee Info label here, if desired