



**INFLUENZA VACCINATION SCREENING & CONSENT**

Patient Name: \_\_\_\_\_  
Last First M.I.

Birth date: \_\_\_\_\_ Current Age: \_\_\_\_\_ Gender: male female

Mailing Address: \_\_\_\_\_  
Street City

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Select all that apply:**

- I request Mercer County Health District to bill my Insurance/Medicaid/Medicare
- I will pay cash/check at time of service
- I have no insurance

Insurance Responsible Party Name: \_\_\_\_\_  
Last Name First Name M.I.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Medicaid/Medicare/Insurance ID Number: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Employer name: \_\_\_\_\_

I understand that I am responsible for all charges incurred by not providing the most current, correct insurance information to the Mercer County Health District (MCHD).

I understand that I am responsible for notifying the MCHD if there is a change in the insurance coverage or funding status. I authorize the MCHD to contact the Insurance responsible party to provide billing information.

**Deductible:** I understand that if my insurance carrier determines that I have not met my deductible, that I will be fully responsible for payment in a timely manner. Payment will be made within 30 days of notification by my insurance carrier or Mercer County Health District.

**I understand that I will assume full responsibility for payment for services, if my insurance denies or does not cover my claim for services rendered at the Mercer County Health District. I accept financial responsibility with or without the use of insurance coverage.**

Authorization to pay benefits to Mercer County Health District: I authorize payment for medical services provided directly to the Mercer County Health District.

\*\*\* No child 18 years and younger eligible for federal vaccine will be denied influenza vaccine because of inability to pay.  
\*\*\* We are able to bill contracted insurance carriers only if all necessary information is provided. A \$15.00 fee will be charged for all returned checks\*\*\*

Signature of Responsible Party: Self, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Turn over for Vaccine Questionnaire!!**

Time of Arrival: \_\_\_\_\_ (S:drive/Drive Thru 8-23-17)

__ HD Tri
__ .25cc Quad
__ .5cc Quad
__ Initials

Payment:
Initials:



MERCER COUNTY

# HEALTH DISTRICT

Print Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PLEASE ANSWER ALL THE FOLLOWING QUESTIONS FOR FLU VACCINES**

- |  | <u>YES</u>            | <u>NO</u>             |
|--|-----------------------|-----------------------|
| 1. Has the person to be vaccinated had a flu vaccine in the past?                                    | <input type="radio"/> | <input type="radio"/> |
| 2. Is the person to be vaccinated sick today?  | <input type="radio"/> | <input type="radio"/> |
| 3. Does the person to be vaccinated have an allergy to eggs, or any component of the vaccine?        | <input type="radio"/> | <input type="radio"/> |
| 4. Has the person to be vaccinated ever had a serious reaction to any influenza vaccine in the past? | <input type="radio"/> | <input type="radio"/> |
| 5. Has the person to be vaccinated ever had Guillain-Barre syndrome?                                 | <input type="radio"/> | <input type="radio"/> |

**I grant permission to the Mercer County Health District to give the requested vaccination to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have read or had explained to me the information from the Vaccine Information Statement and understand the risks and benefits of this vaccine. I have received or have been offered the HIPAA Privacy Notice and the Vaccine Information Statement 8-7-2015.**

**Patient/Parent or Guardian:**

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

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**FOR HEALTH DISTRICT USE ONLY** (S:drive/drive thru 8-23-2017)

FORM REVIEWED AND VACCINE ADMINISTERED BY \_\_\_\_\_

DATE: \_\_\_\_\_ Time \_\_\_\_\_ Lot# \_\_\_\_\_ Site \_\_\_\_\_