



MERCER COUNTY

HEALTH DISTRICT

IMMUNIZATION SCREENING FORM

Patient Name: Last Name First Name M.I. Birthdate Male or Female

Mailing Address City State Zip Phone TEXT: Y N

Table with 4 columns: Question, Yes, No, UNSURE. Contains 13 screening questions regarding patient health, allergies, and vaccination history.

I have been provided the Vaccine Information Sheets for the vaccines received today and had the opportunity to receive the Notice of Privacy Practice for the MCHD.

X (Patient/Parent/Guardian) – PRINT NAME -

X (Patient/Parent/Guardian) – SIGN NAME - Date:

MCHD office use Only * MCHD office use Only * MCHD office use Only * 1-5-2018 S: Drive/Nursing/Forms

Summary table with 3 columns: Statement, Yes, No. Includes statements like 'Patient appears within normal limits' and 'Form reviewed by nurse...'. Includes a row for VFC Status: Not Eligible or Eligible.

Nurse Signature:

Date:



MERCER COUNTY HEALTH DISTRICT

Insurance Form

Insurance Responsible Party Name: Last Name First Name M.I Birthdate Age

Address: City:

State: Zip: SS#:

Home Phone: Cell Phone:

Employer Name: Work Phone:

Please list all other dependents covered under this insurance provider: Relationship to Insured

Name: D.O.B Male Female
Name: D.O.B Male Female
Name: D.O.B Male Female
Name: D.O.B Male Female

***Please check here if client's address is different from insured

Mother's Full Name/Guardian (Please Print)

Father's Full Name/Guardian (please print)

If the client is a minor, who has legal custody? Both Parents Mother Father Guardian

Check all that applies:

- Medicaid/Healthy Start Health Insurance
Health Insurance: Does your health insurance cover vaccines?
No Health Insurance Please note that vaccine provided by the Vaccine for Children or Adult Grant Program will not be denied because of inability to pay administrative fees.
American Indian or Alaskan Native
Medicare

Primary Insurance

Secondary Insurance

Insurance Name:
Policyholder Name:
ID#:
Group#:

Insurance Name:
Policyholder Name:
Date Of Birth:
ID#:
Group#:
Employer:

Please complete both sides of form



MERCER COUNTY

HEALTH DISTRICT

Client Financial Responsibility Form

● 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 (MCHD). I accept financial responsibility with or without the use of insurance coverage.

Please Initial _____

● I understand that I am responsible for all charges incurred by not providing the most current, correct insurance information to the MCHD.

Please Initial _____

● **Deductible:** I understand that if my insurance carrier determines that the claim for services rendered will go towards my deductible, I will be fully responsible for payments in a timely manner. Payment will be made within 30 days of notification by the MCHD.

Please Initial _____

● 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.

Please Initial _____

● I authorize payment for services provided to be paid directly to the MCHD.

Please Initial _____

● The MCHD will bill your insurance carrier if you provide all necessary information. A \$15.00 fee will be charged on all returned checks.

X PRINT Patient/Parent/Legal Guardian Name: _____

X SIGN Patient/Parent/Legal Guardian Name: _____

Relationship to Patient: _____

MCHD Signature _____ Date: _____



Health Services Consent Form

Client's Last Name First Name MI Birthdate Gender M or F

Patient/Parent/Guardian/in loco parentis: Signature _____

Date: _____

I acknowledge that I have been given the opportunity to review and keep the Mercer County Health District(MCHD) Notice of Privacy Practice. I understand that the terms of the Notice of Privacy Practice (NPP) may change. I can obtain an updated NPP by contacting the MCHD by phone or writing. The NPP is posted in the Health Services waiting room and on the website, www.mchdohio.org.

I understand the MCHD may disclose my protected health information (PHI) for the purposes of treatment, payment, and operations. Examples of entities requesting information:

Parent, Guardian, Power of Attorney, Job and Family Services
Day Care, Head Start, Preschools, Schools,
Other Health Departments, Physician offices, Hospitals
Help Me Grow, Women Infant and Children(WIC),
Private Insurance Carriers, Medicaid, Medicare, and Third Party Electronic Biller.

I understand the MCHD may send an appointment reminder or recall by mail/telephone/answering machine/email or text.

Information is uploaded or directly entered into Ohio Immunization Information System(ImpactSIIS). Pre-appointment reminder or missed appointment recall notifications may come from ODH, ImpactSIIS or an affiliated public health organization. Screening data may be entered into ImpactSIIS.

I grant permission for the MCHD to immunize my child in my absence when brought to the clinic by my designee. I understand that I will need to complete the screening, insurance, and patient financial responsibility form and have the designee bring the forms and insurance cards at the time of the appointment. The MCHD clinic staff may call parent/guardian/in loco parentis for teaching and information before providing services. Anyone under the age of 18 is advised to have a designee present at the time of service.

I or my designee will be given the vaccine information sheets for each vaccine given or recommended and will be given the opportunity to address any concerns. I understand the benefits/risks associated with the vaccines to be given. I am aware of the Vaccine Adverse Event Reporting System (VAERS).

The MCHD follows the guidelines and standing orders under the direction of the Advisory Committee on Immunization Practices (ACIP) and the MCHD Medical Director. There are circumstances when the ACIP makes recommendations to reduce the burden of disease that are not approved by the Food and Drug Administration. This is called Off Label. You will be notified if you are receiving an off-label vaccine. For more information please go to www.immunize.org.