MERCER COUNTY HEALTH DISTRICT

INFLUENZA VACCINATION SCREENING & CONSENT

___ HD Quad

___ Flublok Quad

___ Standard Quad

_____ Initials

Through Put:

Arrival Time _____

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/Medicaid Name: _____

Medicaid/Medicare/Insurance ID Number: _____ Group Number: _____

Insurance Holder's Name: _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

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. *We are able to bill contracted insurance carriers only if all necessary information is provided.

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.**
*****A $15.00 fee will be charged for all returned checks.**

Signature of Responsible Party: Self, Parent/Guardian: _____

Date: _____

Payment:

Initials:

Turn over for Vaccine Questionnaire!!

MERCER COUNTY HEALTH DISTRICT

Print Patient Name:_____ **DOB**:_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS FOR FLU VACCINES

	YES	NO
1. Is the person to be vaccinated sick today?	○	○
2. Has the person to be vaccinated had a flu vaccine in the past?	○	○
3. Does the person to be vaccinated have an allergy to eggs, or any component of the vaccine?	○	○
4. Has the person to be vaccinated ever had a serious reaction to any influenza vaccine in the past?	○	○
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?	○	○
6. Is there a health problem such as heart disease, lung disease, or diabetes?	○	○
7. Is the person to be vaccinated pregnant?	○	○

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 8-6-2021.

Patient/Parent or Guardian:

SIGNATURE_____

DATE_____

FOR HEALTH DISTRICT USE ONLY (S:drive/drive thru 8-30-2021)

FORM REVIEWED AND VACCINE ADMINISTERED BY _____

DATE: _____ TIME: _____ Site: LD RD

Lot# P or M _____ Site: LVL RVL