MERCER COUNTY HEALTH DISTRICT

IMMUNIZATION SCREENING FORM

Patient Name: _____ _____ Male or Female

Last Name First Name M.I. Birthdate

_____ _____

Mailing Address City State Zip Phone **TEXT: Y N**

Please answer the following questions:	**Yes**	**No**	**UNSURE**
1. Who is the patient's Primary Care Physician?			
2. Is the person to be vaccinated sick today?			
3. Are there any allergies to medications, eggs, gelatin, other foods, vaccines or latex?			
4. Has there ever been a serious reaction after receiving a vaccination?			
5. Is there a health problem; lung, heart, kidney, asthma, kidney, or metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on a long-term aspirin therapy?			
6. If your child is a baby, have you ever been told he or she has had intussusception			
7. Has there been a seizure, brain, or other nervous system problem in any immediate family member? (patient, parent or sibling)			
8. Is there any cancer, leukemia, AIDS, or any other immune system problem?			
9. Is there a parent, brother, or sister with an immune system problem?			
10. In the past 3 months, has there been medication taken that affect the immune system such as cortisone, prednisone, steroids, anticancer drugs, or any radiation treatments; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis?			
11. Has there been a blood transfusion, blood products, immune (gamma) globulin or antiviral given in the past year?			
12. For females: Is there any chance of pregnancy now or during the next month?			
13. Has the patient received vaccinations in the past 4 weeks?			

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 OFFICE USE ONLY ** MCHD OFFICE USE ONLY*****

	Yes	**No**
Patient appears within normal limits.		
Patient/Parent/Guardian denies concerns.		
Form reviewed by nurse and all concerns addressed.		
Circle VFC Status: **Not Eligible** or **Eligible** (choose: Medicaid Uninsured Underinsured Amer. Indian or Alaskan Native)		

Nurse Signature: _____ *Date:* _____

MERCER COUNTY

HEALTH DISTRICT

INSURANCE FORM

Insurance Responsible Party Name:_____ _____ _____ _____
(Person who holds the insurance) Last Name First Name M.I Birthdate Age

Address:_____ City: _____ State:_____ Zip:_____

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 _____
(Client being seen)

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? □ Yes □ No

□ 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

Insurance Name:_____

Policyholder Name:_____

ID#: _____

Group #: _____

Seconday Insurance

Insurance Name:_____

Policyholder Name:_____

Address: _____

_____

ID#_____

Employer: _____

Please complete both sides of form

220 W Livingston St - B 152, Celina, Ohio 45822
Ph: (419)586-3251- Fax: (419)586-3910- E-Mail: healthdistrict@mchdohio.org
Website: www.mchdohio.org - An Equal Opportunity Employer

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 or all returned checks.

X PRINT Patient/Parent/Legal Guardian Name: _____

X SIGN Patient/Parent/Legal Guardian Name: _____

Relationship to Patient: _____

MCHD Signature _____ Date: _____

Please complete both sides of form

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MERCER COUNTY

HEALTH DISTRICT

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.