SOUTHEAST HEALTH DISTRICT

_____ County Health Department

PIN #:_____

I have been given a copy and have read, or have had explained to me, the information on the VACCINE INFORMATION STATEMENTS for the vaccine(s) checked below, and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) that will be given to me or the person for whom I am authorized to represent.

VACCINE(S) TO BE GIVEN:

_____ **FLU** (8/7/15) _____ **PCV13** (11/05/15) _____ **PNV (PPSV23)** (4/24/15) _____**TDAP** (2/24/15) _____ **TD** (4/11/17)

_____ **HEP A** (7/20/16) _____ **HEP B** (7/20/16) _____ **HPV** (12/02/16) _____ **MCV4/MPSV4** (3/31/16)

_____ **MMR** (2/12/18) _____**VZV** (2/12/18) _____**Zoster** (2/12/18) **Other:**_____(VIS date:_____)

INFORMATION ON PERSON TO RECEIVE VACCINE Please Print	**FOR CLINIC USE**		
	DATE	**DATE**	**DATE**
FULL LEGAL NAME (Last, First, Middle) BIRTHDATE	**VACCINE TYPE**	**VACCINE TYPE**	**VACCINE TYPE**
AGE RACE SEX PHONE #	**DOSAGE**	**DOSAGE**	**DOSAGE**
ADDRESS	**ROUTE/SITE**	**ROUTE/SITE**	**ROUTE/SITE**
CITY STATE ZIP	**MANUF./LOT#**	**MANUF./LOT#**	**MANUF./LOT#**
E-MAIL ADDRESS:_____			
SIGNATURE OF PERSON TO RECEIVE VACCINE (OR) PERSON AUTHORIZED TO GIVE CONSENT DATE			
X_____	**NURSE'S SIGNATURE**_____		

MEDICARE #	**MEDICAID/PEACHCARE #**

Insurance Name: (CIRCLE) **AETNA BCBS CIGNA COVENTRY UHC OTHER**	**GROUP# or PLAN TYPE (Attach copy of card)**	**MEMBER ID #**

This portion only required to be completed IF you are covered by Medicare, Medicaid, PeachCare, BCBS, Cigna, Coventry, UHC or AETNA insurance and would like the Health Department to bill for vaccination(s); OR if your employer or other agency will be responsible for payment.

Insurance Declaration of Non-Covered Services

Patient Name_____ Patient DOB_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein.

By providing us with your insurance information, we will make every attempt to bill your insurance company. In the event that the service is not covered or denied, you will be mailed a bill along with a copy of the Explanation of Benefits (EOB). At that time, you will be expected to make payment for the services you received.

By signing below, I agree to pay for the service or the balance of the service after insurance payment. I also agree to pay any applicable copay and/or deductible at the appointment time.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein.

(MDCR Part B Added 10/2015/updated 08/2018)

X_____ _____

Signature of Policyholder Date

_____

Signature of Claimant if other than Policyholder