

## Immunization Signature Card

Client #: \_\_\_\_\_

Male  Female

Last Name	First Name	Mid Initial	Date of Birth
Name of Parent or Legal Guardian (for minors)			Parent or legal Guardian Date of Birth ( )
Mailing Address	City	State	Zip Phone

The following questions are about the person receiving the vaccinations:

- |   |  | Yes                      | No                       |
|---|--|--------------------------|--------------------------|
| 1. Are you ill or had a fever or diarrhea today?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have seizures or brain problems?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had a serious reaction to any vaccine in the past?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a chronic illness being treated by a physician?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you received any vaccination(s) in the past four weeks?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you received a transfusion of blood or plasma or been given immune globulin in the past year?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you pregnant or plan to become pregnant in the next three months?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you American Indian or Alaskan Native?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you allergic to any of the following: <input type="checkbox"/> Medications <input type="checkbox"/> Vaccines <input type="checkbox"/> Eggs <input type="checkbox"/> Latex <input type="checkbox"/> None                |  |                          |                          |
| 10. Do you have any of the following: <input type="checkbox"/> Cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> AIDS <input type="checkbox"/> Any other immune system problem? <input type="checkbox"/> None |  |                          |                          |
| 11. Have you taken the following treatments in the last three months: <input type="checkbox"/> Steroids <input type="checkbox"/> Anticancer drugs <input type="checkbox"/> Radiation treatment <input type="checkbox"/> No    |  |                          |                          |
| 12. Do you have insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please initial: _____   |  |                          |                          |
| 13. If yes, please mark the type of insurance you have. <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private  |  |                          |                          |

Ins Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

*Please present Medicaid, Medicare, or Insurance Card to the Receptionist*

Review statements and sign below:

- I understand the benefits, risks, or complications from the vaccine(s) and give consent to SCPHD to give vaccinations to the person listed above.
- I have been offered a copy of South Central Public Health District's (SCPHD) Notice of Privacy Practices.
- I also understand that I am responsible for all payment of services not covered by my insurance.
- I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD. This includes but is not limited to Medicaid, Medicare, and private insurance.
- I understand immunizations are not mandatory and may be refused for religious or other grounds.
- I have been given copies of the Vaccine Information Statement(s) for vaccine(s) being given today. (Further information about the vaccine(s) is available upon request.)

X		Signature			Date
X		Reviewed - Signature			Reviewed - Date
X		Reviewed - Signature			Reviewed - Date

**\*IRIS Enrollment\***

*Please be advised that all immunization records will be entered into the IRIS (Immunization Reminder Information System) effective July 1, 2010. Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program at (208) 334-5931 and ask for a deletion form.*

**\*FOR OFFICE USE ONLY\***

	Site	Lot #	Vaccine Type	Site	Lot #
SMST	_____	_____	Other _____	_____	_____
Flu	_____	_____	Other _____	_____	_____
Pneumonia	_____	_____	Other _____	_____	_____
Nurse Signature:				Nurse Signature:	



## Financial Consent

The goal of our clinic is to provide you with quality health care at a reasonable cost. South Central Public Health District (SCPHD) is not a free clinic. A limited number of fees are available on a sliding scale based upon income and family size. In order to remain affordable, we depend upon you to make prompt payment for services and supplies. In an effort to do this, we have implemented a Financial Policy. This Financial Policy shares responsibility among all our clients.

### FINANCIAL POLICY

The following is the Financial Policy, which we require you to read and sign prior to treatment.

- Full payment is due at time of service (including medications).  
**Exception:** we offer a payment plan with prior approval.
- We accept cash, checks, and credit cards.
- Donations are appreciated for all services.
- No one receiving Vaccine for Children (VFC) vaccines will be denied services due to inability to pay.
- Your account balance does not affect your ability to continue receiving services.
- Your account may be turned over to a collection agency if no payment is received within 120 days after an agency billing.
- We may adjust your account balance to correct any billing errors found after the time of service.

### REGARDING INSURANCE:

- All clients must complete a Financial Request Consent before receiving services. Please present your insurance/Medicaid/Medicare card at the reception desk.
- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD;.
- You may use our services, but we recommend you check with your insurance company regarding coverage.
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, and perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian, or spouse).
- Please list those whom you give permission to speak to SCPHD or billing representative regarding your account other than yourself:

\_\_\_\_\_ Name

\_\_\_\_\_ Relationship

\_\_\_\_\_ Name

\_\_\_\_\_ Relationship

I have read the Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment for all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date