South Central Public Health District
Prevent. Promote. Protect.

CLIENT CONSENT

_____ _____ _____

Patient Name (Please Print) Patient DOB Parent Name If Minor (Please Print)

_____ _____

Signature Date

CONSENT FOR MEDICAL SERVICES

Immunization Services

- I have been offered copies (electronic and/or paper) of the Vaccine Information Statements for all vaccines being given today.
- I understand that vaccines are not mandatory and may be refused for religious and/or other grounds.
- I understand the benefits, risks, or complications from vaccines. (Further information about the vaccines being offered is available upon request).
- I understand that all immunization records will be entered into the IRIS (Immunization Reminder Information System). Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program.
- I have been offered a copy of SCHPD's Notice of Privacy Practices.
- I consent to receive vaccinations provided by SCPHD for myself or for this child for whom I am the parent or legal guardian.

FINANCIAL CONSENT

- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD.
- 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, or 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).

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