South Central Public Health District
Prevent. Promote. Protect.

IMMUNIZATION SIGNATURE CARD

CLIENT NUMBER _____

Last Name	First Name	Mid Initial	Male ☐ Female ☐	Birthdate (Mo/Day/Year)

Name of Parent or Legal Guardian	Mother's Maiden Name and Date of Birth

Mailing Address	City	State	Zip	Telephone ( )

The following questions are about the person receiving the vaccinations:

	YES	NO
1. Are you ill today or have you had a fever or diarrhea?	☐	☐
2. Are you allergic to any of the following? medications ☐ vaccines ☐ eggs ☐ latex ☐		
3. Do you have seizures or brain problems?	☐	☐
4. Have you had a serious reaction to a vaccine in the past?	☐	☐
5. Do you have a chronic illness being treated by a physician?	☐	☐
6. Do you or any person who lives with you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐
7. Have you or any person who lives with you taken any steroids, anticancer drugs, or x-ray treatments in the past three months?	☐	☐
8. Have you received a transfusion of blood or plasma or been given immune globulin in the past year?	☐	☐
9. Are you pregnant or plan to become pregnant in the next three months?	☐	☐
10. Are you American Indian or Alaskan Native?	☐	☐
11. Do you have insurance, Medicaid, or Medicare?	☐	☐
12. Does it cover immunizations?	☐	☐
13. If yes, circle what type of insurance you have? MEDICAID MEDICARE PRIVATE		

Company: _____ **Group Number:** _____ **Policy Number:** _____

PLEASE PRESENT, MEDICAID, MEDICARE OR INSURANCE CARD TO THE RECEPTIONIST

Initial statements below:

_____ I understand the benefits, risks, or complications from the vaccine(s) and request that the vaccine(s) indicated be given to me or to the person named for whom I am authorized to make this request. (Further information about the vaccines is available upon request.)

_____ I have been provided with a copy of South Central Public Health District's Notice of Privacy Practices.

_____ I also understand that I am responsible for payment for all services not covered by my insurance.

_____ I authorize release of medical information necessary to process medical claims and authorize payment of benefits to South Central Public Health District. This includes Medicaid, Medicare, and private insurance.

_____ I understand immunizations are not mandatory and may be refused on religious or other grounds.

X_____ _____

Signature Date

IRIS ENROLLMENT

Please be advised that all immunization records will be entered into the IRIS 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 for a deletion form.

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Family and Children's Health Services Financial Policy

The goal of our clinic is to provide you with quality health care at a reasonable cost. South Central Public Health District is not a free clinic. Most fees are based 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.

FINANCIAL POLICY

The following is our 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 some credit cards.
- Donations are appreciated for all services.
- No one 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.

REGARDING INSURANCE/MEDICAID/MEDICARE:

- All clients must complete a Financial Request Consent before receiving services. Please present your insurance/Medicaid/Medicare card at the reception desk.
- South Central Public Health District may bill your insurance company for you, and the payment may come directly to South Central Public Health District.
- Currently we are not participating in HMO or Participating Provider plans (except Blue Cross PPO). You may use our services, but we recommend you check with your insurance company regarding coverage.
- If you have pharmacy coverage, ask for a prescription. This usually will save you money.
- Whether your insurance company pays or not, your account balance is your responsibility.
- If your insurance company does not pay on your account in a reasonable amount of time, the balance will automatically be billed to you directly.
- Some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under your insurance program.
- 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).

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I have read the Financial Policy. 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 South Central Public Health District.

_____ _____

Client Signature Date