

Please Print!

NAME: _____ Date of Birth: _____ Male Female
 (Last) (First) (MI) (month/day/year)

STREET: _____ Age: _____ (months if under 3 years of age)

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

Marital Status: S M D W X

Please answer the following questions: Patient speaks: English Arabic Spanish Other: _____
 Patient is: (select all that apply) American Indian Alaskan Native Asian Black/African American White
 Patient is: Arabic Hispanic Other: _____ Patient is a Veteran: Yes No
 Homeless Status: Not homeless Shelter Transitional Doubling up Street Other Unknown
 Total annual household income: _____ Number in family (adults and children): _____

PAYMENT & INSURANCE INFORMATION: Please fill out legibly and completely.

Important Notice: We can only bill Medicare B, listed Commercial Insurance if PRIMARY. No Medicare managed care plans (i.e. BCN, any Medicare Advantage plan) or secondary coverage. You are responsible for full payment if insurance rejects claim.

<input type="checkbox"/> Medicare B Write ALL numbers and letters: _____ _____	Part A (hospitalization) <input type="checkbox"/> Yes <input type="checkbox"/> No If only A, not eligible. Pays full price. Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No Part D (pharmacy) or Managed care plan (such as BCN, Plus Blue, Humana, Auto groups, School employees, or any Medicare Advantage Plan) <input type="checkbox"/> Yes <input type="checkbox"/> No ICHD cannot bill, refer back to physician or pay full price here.
<input type="checkbox"/> Medicaid Recipient ID Number: _____ _____	Plan Name: <input type="checkbox"/> Straight <input type="checkbox"/> PHP _____ <input type="checkbox"/> McLaren <input type="checkbox"/> Other _____ Adults: No Pending, Spend down, or ER Only - does not cover
<input type="checkbox"/> PRIVATE INSURANCE Name and date of birth for the person who insurance is under Name: _____ Date of birth: _____	<input type="checkbox"/> Other insurance coverage? (name) _____ Which insurance is Primary _____ <u>Attach copy of both sides of insurance card</u>
<input type="checkbox"/> IHP Plan A or B (circle one) Group No: _____ Number: _____	A plan pays only copay of \$3.00 B plan pays copay of \$5.00 plus vaccine price (see fee sheet)
<input type="checkbox"/> VFC Eligible 6mos-18 yrs (Non-Medicaid)	Pays administration fee \$16 w/o eligible. Fill out financial screening form.
<input type="checkbox"/> Cash/Check	RECEIPT # _____

Staff Use Only Below This Line

Vaccine	Date Vaccine & VIS Given	Clinic Site	Vaccine Manufacturer	Vaccine Lot #	Site ¹	Vaccine Administrator	VIS Date	VFC Status ² Circle letter
Influenza IM .50 IM Prfill .50 IM Prfill .25 Nasal			<input type="checkbox"/> SP <input type="checkbox"/> GSK <input type="checkbox"/> Novartis <input type="checkbox"/> MedImmune				2008-2009	M U N D P
Pneumonia IM			Merck				7/29/97	M U N D P

¹ Site Key: LA = left arm, RA = right arm, LL = left leg, LR = right leg, N = nasal

² VFC status for those ≤ 18 years of age: M = Medicaid, U = Uninsured, N = Native American, D= Underinsured

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(Last) (First) (MI) (month/day/year)

PLEASE CHECK THE APPROPRIATE BOX FOR EACH QUESTION:

Health Screening Questions:

For ALL Flu Vaccine Recipients

1. Have you had a fever within the past 2 days?..... Yes No
2. Have you had a flu shot before? Yes No
3. Have you ever had a serious reaction to a flu shot or any previous immunizations?..... Yes No
4. Do you have any allergies? If so, list _____ Yes No
5. Do you have a history of Guillain Barré Syndrome?..... Yes No
6. Have you had a pneumonia shot in the past? If yes, year _____ Yes No

For Flu Mist ONLY (Nasal Spray Vaccine):

1. Are you between 2 years through 49 years of age? (Not yet 50) **If no, STOP HERE!** Yes No
2. Do you have any diagnosed medical condition? _____ Yes No
3. Do you take prescribed medications on a regular basis?..... Yes No
4. Are you pregnant or breast feeding?..... Yes No
5. Do you have a history of asthma?..... Yes No
6. Do you have close contact to a **severely** immune compromised person?..... Yes No

PLEASE READ AND SIGN THE STATEMENT BELOW:

Receipt of Privacy Notice

I acknowledge I have been offered an Ingham County Health Department Notice of Health Information Practices.

I accept I decline

Authorization for Vaccine Administration

I have read or have had explained to me the information in the Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specified vaccine(s). I ask that the vaccine(s) be given to me or to the person named for whom I am authorized to make this request.

If applicable, I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits for related services with payment made to Ingham County Health Department.

I authorize the release of any information necessary to process this claim. I request that any money due me for medical benefits be assigned to Ingham County Health Department. I realize that I am responsible for payment for any and all differences. I further attest that as of the date of my signature, insurance and income information provided by me are complete and truthful.

The authorization for release of information is effective for one year from date of service.

PRINT Parent/Guardian Name if Client is a minor: _____

Patient or Parent/Guardian Signature: _____ Date: _____