



# Immunization Encounter Form

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_

**Address:** \_\_\_\_\_ **#:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone #:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Email:** \_\_\_\_\_ **Gender:**  Male  Female

**Race (Circle):** African American, Alaskan Native, Asian/Pacific Islander, Native American, White, Other **Ethnicity:** Hispanic  Yes  No

**Utah Medicaid?**  Yes  No **Medicare?**  Yes  No **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Health Ins?**  Yes  No **Insurance Name:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insurance Policy Holder Name:** \_\_\_\_\_ **Birthdate:** \_\_\_/\_\_\_/\_\_\_ **Relation to patient:** \_\_\_\_\_

**Phone #:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Address:** \_\_\_\_\_

<i>Please answer these questions concerning the individual receiving immunizations today by checking the boxes</i>	Yes	No
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?		
Are you a child <b>less than 5 years of age</b> with recurrent wheezing?		
Do you have any chronic diseases/conditions?		
Do you have allergies to medications, food, latex or any vaccine?		
Have you had a serious reaction to a vaccine in the past?		
Have you ever had a seizure, Guillain-Barre syndrome, or other brain/nervous system problem?		
Do you <b>currently</b> have or <b>currently</b> live with someone who has cancer, leukemia, HIV/AIDS, or any other immune system problem?		
In the past 3 months, have you taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, anticancer drugs; or had radiation treatments?		
Are you a <b>child</b> or adolescent taking aspirin therapy?		
Have you received a transfusion of blood or blood products, or been given an immune (gamma) globulin in the past year?		
If you are female, are you pregnant or at risk of becoming pregnant within the next month?		
Have you received any vaccinations in the past four weeks?		
In your lifetime, did you ever have the Chickenpox (Varicella) disease/rash?		

I have been given a copy and have read or had explained to me, the information contained in the **Vaccine Information Statement(s)** about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the **Notice of Privacy Practices**. I agree that the immunizations may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Utah County Government and their employees from all claims arising from such immunizations.

**JURISDICTION AND VENUE** The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

I **understand** that my health insurance coverage could have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance for any reason. If I fail to pay for these services and charges within 90 days of receiving notice that the charges are not covered for any reason, my account will be turned over to a collection agency. I hereby expressly agree to pay all costs of collection fees including an additional collection of 18%. I further agree to pay all court costs and attorney's fees should legal action become necessary.

**Due to the higher cost to provide insurance billing services**, I understand that the amount billed to my insurance company is higher than the discounted amount I would have paid if I had chosen to pay at the time of service. I understand that I will be charged the full cost of the vaccines if I do not pay today and my insurance company does not cover the costs for any reason. I hereby request and authorize the Utah County Health Department to submit claims to my Medicaid, Medicare, and/or UCHD contracted insurances. I understand that if I have insurance that covers vaccines, I am not eligible for the Vaccine for Children program.

**IF RECEIVING YELLOW FEVER, TYPHOID, JAPANESE ENCEPHALITIS, CHOLERA OR RABIES VACCINES, A NEWBORN SCREEN OR TB TEST**, I acknowledge that I have elected to be seen as a **SELF-PAY PATIENT** and that the Utah County Health Department will **NOT** bill my insurance for the above mentioned vaccines. If I choose to seek reimbursement from my insurance, Utah County Health Department is **NOT** responsible for any amount that my insurance company does not compensate. I am agreeing to assume **ALL** financial responsibility and to pay Utah County Health Department the total amount due at the time of service.

**Authorization Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

If Signature **NOT** Client's, Print Name \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_ **Relation to client** \_\_\_\_\_

Date printed on Vaccine Information Sheet: MULTI VACCINES 4/01/20; CHOLERA 10/30/19; DTAP/DT 4/01/20; HEP A 7/20/16; HEP B 8/15/19; HIB 10/30/19; HPV9 10/30/19; IG 5/1/94; INFLUENZA 8/15/19; JE 8/15/19; MENACWY 8/15/19; MEN B 8/15/19; MMR 8/15/19; MMRV 8/15/19; PPSV23 10/30/19; PCV13 10/30/19; POLIO 10/30/19; PPD 4/25/05; RABIES 1/8/20; ROTAVIRUS 10/30/19; SHINGLES 10/30/19; TD or TDAP 4/01/20; TYPHOID 10/30/19; VARICELLA 8/15/19; YELLOW FEVER 4/01/20

Vaccine	Category	Site	Lot #	Dose	Price	Date of Service: ___/___/___	
DTAP/IPV 4-6				0.5		<b>NOTES:</b>	
HEP A/HEP B				1.0			
MENINGITIS 2-55				0.5		<b>INSURANCE</b>	
MMR/VARICELLA 1+				0.5			
TDAP 7+				0.5		<b>VFC Eligible</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
VARICELLA 1+				0.5			
FLU				0.5		<b>Payment Information</b>	
						<input type="checkbox"/> Check# _____ <input type="checkbox"/> Cash <input type="checkbox"/> Voucher <input type="checkbox"/> C/C App# _____	
						<b>Amount Paid</b>	<b>Operator ID</b>
Total Costs for Today's Vaccines/Insurance Provider/ Contract							
Nurse One ID#:		Nurse Two ID#:				<input type="checkbox"/> Live Vaccine <input type="checkbox"/> Wait 15 min	