Immunization Encounter Form

version 01-09-26

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:** _____

Please answer these questions concerning the individual receiving immunizations today by checking the boxes	**Yes**	**No**
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?		
For children ages 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?		
Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, rheumatoid arthritis, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?		
Do you have allergies to medications, food, a vaccine component, or latex?		
Have you had a serious or allergic reaction to a vaccine in the past?		
Have you ever had a seizure, Guillain-Barre syndrome, or other brain/nervous system problem?		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
Do you have a parent, brother, or sister with a congenital or hereditary immune system problem?		
In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, biologics, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, ulcerative colitis, eczema or psoriasis; or have you had radiation treatments?		
Is the patient a child or adolescent that is taking aspirin therapy?		
In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?		
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?		
Have you ever been diagnosed with a heart condition (myocarditis or pericarditis), or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with COVID-19 virus?		
For babies: Have you ever been told the child had intussusception?		

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.

Signature of Patient (or Responsible Party if patient under age 18): _____Date:____/____/_____

If Signature **NOT** Patient's, Print Name _____ DOB: ___ / ___/ ____ Relation to patient_____

Vaccine	**Category**	**Site**	**Lot #**	**Dose**	**Price**
Total Costs for Today's Vaccines/Insurance Provider/ Contract					

Date of Service: _____/_____/_____

NOTES:

INSURANCE

VFC Eligible □ Yes □ No

Payment Information

□Invoice#_____ □ Cash □ Voucher

□ C/C _____□ Check#_____

Amount Paid	**Operator ID**

Nurse One ID#: Nurse Two ID#: □ Live Vaccine □ Wait 15 min