Utah County
HEART of UTAH
Health Department

IMMUNIZATION ENCOUNTER FORM

Offsite Clinic Operator ID# _____

Patient Name: (First, Middle Initial, Last) _____ Date of Birth: ____/____/____ Age: ____

Gender: ☐M ☐F Phone #: _____ SS# ____-____-____ Email: _____

Address: _____ #: _____ City: _____ State: _____ ZIP: _____

Race: ☐White ☐Alaskan Native ☐Black or African American ☐Native American ☐Asian/Pacific Islander ☐Other Ethnicity: Hispanic? ☐Y ☐N

Health Insurance? ☐YES ☐NO Please have insurance information ready to present

Subscriber Name: _____ DOB: ____/____/____ Relationship: _____

Screening Questions for Today's Immunizations *Please answer these question concerning the individual receiving immunizations today by checking the boxes below*	Yes	No	Don't Know
Sick today?			
Do you have any chronic diseases? Child < 5 years of age with recurrent wheezing?			
Have allergies to medications, food, latex or any vaccine?			
Had a serious reaction to a vaccine in the past?			
Ever had a seizure, brain, Guillain-Barre syndrome, or other nervous system problem?			
Has cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, anticancer drugs; or had radiation treatments? Child or adolescent taking aspirin therapy?			
Received transfusion of blood or blood products, or been given an immune (gamma) globulin in the past year?			
Pregnant or at risk of becoming pregnant within the next month?			
Received any vaccinations in the past four weeks?			
Ever had Chickenpox?			

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 information on this form 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. I understand that if I have insurance that covers vaccines, I am not eligible for the Vaccine for Children program.

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 35%. 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.

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.

IF **RECEIVING YELLOW FEVER, TYPHOID VACCINES OR TB TESTING** I acknowledge that I have elected to be seen as a SELF-PAY PATIENT for these services. Utah County Health Department will NOT bill my insurance for these 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 NOT client: Please Print Name: _____ DOB: ____/____/____ Relationship: _____

Date printed on Vaccine Information Sheet: MULTI VACCINES 10/22/14; DTAP/DT 05/17/07; HEP A 10/25/11; HEP B 02/02/12; HIB 04/02/15; HPV 05/17/13; HPV9 04/15/15 IG 05/1/94; INFLUENZA 08/19/14; MENING 10/14/11; MMR 04/20/12; MMRV 05/21/10; PPSV23 4/24/15; PCV13 02/27/13; POLIO 11/08/11; PPD 04/25/05; RABIES 10/06/09; ROTAVIRUS 04/15/15; SHINGLES 10/06/09; TD 02/24/15; TDAP 02/24/15; TYPHOID 05/29/12; VARICELLA 03/13/08; YELLOW FEVER 03/30/11;JE 01/24/14

CPT CODE	VACCINE	CATEGORY	SITE	LOT #	DOSE	COST	PAYMENT INFORMATION
							Cash Check Credit Card Contract
							INSURANCE
							Amount Paid:
Total Costs for Today's Vaccines/Insurance Provider/Contract:							Operator ID#:

Nurse One ID # Nurse Two ID# Wait 15 min ☐ Live Vaccine ☐ Notes: