LastName: _____ **FirstName:** _____ **BirthDate:** _____ **Sex:** _____ **RespPartyID**

Street: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Email:** _____

Insurance : _____ **IdentificationNo:** _____ **Group#:** _____ **Co-Pay:** _____ **Deductible:** _____

Doctor's Name			
Last	First	Address	City / Zip

Please provide copy of your insurance, Medicaid or Medicare Card

PLEASE COMPLETE:

1) Are you allergic to:

Eggs Y/N Latex Y/N Medications Y/N If yes, please list:

_____

2) Do you have a fever today? _____

3) Have you had any vomiting or diarrhea in the last 48 hours? _____

4) Are you pregnant? _____ * If yes, notify staff immediately!*

5) Have you ever had a life-threatening allergic reaction to the flu vaccine?_____

6) Have you ever had Guillain-Barre Syndrome (GBS)?_____

7) Have you received services from OCHD prior to today (Other than WIC)?_____

Signature of Parent / Guardian /Self (must be 18 years or older) Date

□ Self-Pay	Insurance Accepted
□ Medicare Part B	Aetna HealthAlliance
□ Medicaid	Alliance HFN
□ Insurance	BC BS Humana
Payment	Cigna Medicare
□ CoPay	Coventry Public Aid
Amt Paid:	Ecoh UHC
Cash, CC or CK#	MCO
	BC BS Illinicare
	Aetna BH Meridian

Other Payor:

□ Ogle County
□ Village of Progress
□ Sinnissippi
□ Other : _____

OFFICE USE ONLY:

Immunization				Route	MFG	Lot#	NDC#	Left/Right	Arm/Leg	VIS
Flu 6 mos&up	Fluarix (1)	90686	$35	IM	S			L / R	A / L	8/7/2015
Flu	Fluarix Quad (1)	90686	$35	IM	S	7R9NM	N4-58160-887-52	L/R	A/L	8/7/2015
Flu 4+yrs	Flucelvax (1) (S)	90674	$35	IM	S			L / R	A / L	8/7/2015
Flu-4+yrs	Flucelvax (1) (M)	90756	$35	IM	S					
High-Dose	Fluzone Quad(1)	90662	**$82**	IM	S	UJ764AA	N4-49281-0121-65	L / R	A / L	8/7/2015
				IM						

Nurse(s) Signature administering procedure	Date			□ VIS
		□ VFC $23.75	□ CHIP/XXI	□ HIPPA
		□ Private	□ 317 $23.75	□ ICARE □ Entered in ClientDB

LastName: _____ **FirstName:** _____ **BirthDate:** _____ **Sex:** _____ **RespPartyID**

Street: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Email:** _____

Insurance : _____ **IdentificationNo:** _____ **Group#:** _____ **Co-Pay:** _____ **Deductible:** _____

FINANCIAL POLICY

Private Insurance:	As a courtesy, we will file a claim on your behalf. However, if your insurance company denies payment, you will be responsible to pay the balance of unpaid charges.
Managed Care / HMO's or PPO's	**If your plan is a Managed Care / HMO and Ogle County Health Department (OCHD) is not a provider in your plan, we cannot bill for your service. If you choose to receive our services, you are responsible for payment in full at the time of service.**
Medicare	We can only accept Medicare Part B for flu or pneumonia vaccines. Any other service, must be paid in full at time of service.
Self-Pay	All services must be paid in full at time of service. We accept cash, check or credit card
Co-Payments	I understand that any co-payment and any unsatisfied deductible is my responsibility and will pay such co-payment at time of service.

IMMUNIZATIONS

I have read, or have had explained to me, the information in the Vaccine Information sheet about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and know that the vaccine(s) checked on the service sheet are to be given to me or to the person named above for whom I am authorized to make this request.

*****The Ogle County Health Department will make a reasonable attempt to vaccinate your child. If your child is not cooperative during the school flu clinic, department staff will not restrain or use force to administer vaccinations. If department staff decides not to vaccinate your child, you are invited to schedule an appointment at one of our office locations by calling 815-562-6976.*****

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the OCHD to supply copies of records to schools; medical facilities as needed; and enter the information to the State of Il DHS; ICARE and billing system(s) at OCHD.

I further authorize OCHD to release information to submit claim to third party payor and consent to assignment of benefits to OCHD

I authorize payment of medical benefits from my insurance carrier to OCHD for services received.

PRIVACY NOTICES

I Have read, or have had explained to me, the "Joint Notice of Privacy Practice" by the OCHD.

CREDIT CARD INFORMATION

□ I hereby authorize OCHD to charge the services received today on my behalf for the above mentioned patient/client.

□ I hereby authorize OCHD to charge the copay/deductible for the services received today on my behalf for the above mentioned patient/client.

□ I hereby authorize OCHD to charge the services received today on my behalf for the above mentioned patient/client for the amount that my insurance denies or applies to deductibles orco-payments.

The OCHD will follow stringent security procedures in handling credit/debit card information.

Signature _____Date_____

_____

Please Print