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David Didden, M.D.
Physician Director

IMMUNIZATION PATIENT INFORMATION

Patient's Name ______________________ (Last) ______________________ (First) ________ (Middle Initial)

Mailing Address ____

City ______________________ **State** __________ **Zip** __________

Date of Birth __________ (Month/Day/Year) **Age** ______ **Gender** ________ (Male/Female) **SS#** ______________ **Race** ________ (optional)

Home Phone # ______________ **Cell Phone #** ______________ **Work Phone #** ______________

PARENT/GUARDIAN INFORMATION (for patients under 18)

Guardian Name ______________________ (Last) ______________________ (First) ________ (Middle Initial)

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The Jefferson County Health Department (JCHD) Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of this notice is available upon request. By signing this form, you acknowledge that the JCHD Notice of Privacy Practices was made available to you.

________________________________ ________________

Patient/Patient Representative's Signature **Date**

PAYMENT INFORMATION

☐ **Option 1: Self-pay -** Cash, check, or credit card payments are accepted. Payment plans are available for those unable to pay in full. The first payment is due on the date of service and the remaining payments will be due within a six month period.

☐ **Option 2: Bill Insurance – TURN OVER AND COMPLETE REVERSE SIDE**

☐ **Option 3: VFC –** Routine immunizations for uninsured and underinsured* patients 18 and under are covered by the Vaccines for Children Program.

☐ **Option 4: Bill Employer or other organization – COMPLETE SEPARATE BILLING CONSENT FORM**

*The VFC Program considers children underinsured if their health insurance: A) does not cover vaccines, B) does not cover certain specific vaccines, OR C) has a fixed dollar limit or cap for vaccines - once that fixed dollar amount is reached the child would be eligible for VFC.

Health Department Use Only – Patient Payment			
Amount Paid	**Cash**	**Credit**	**Check #**
Receipt/Invoice #	**Payment Plan**		
Staff Signature			

ONLY COMPLETE THIS PAGE IF WE ARE BILLING YOUR INSURANCE

Health Insurance Information

PRIMARY INSURANCE: ☐ None Does your Primary Insurance cover immunizations? ☐ YES ☐ NO

Insurance Company Name: ______________________________ Plan name: ____________________________

ID Number: __________________________________ Group Number (if any):____________________________

Policy Holder:______________________________ __________________________ __________ ______
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____________ Relationship to Patient____________ SS # _________________

Policy Holder Address (if different from patient): ____

Home Phone#___________________ Cell Phone #___________________ Work Phone # ___________________

SECONDARY INSURANCE: ☐ None Does your Secondary Insurance cover immunizations? ☐ YES ☐ NO

Insurance Company Name: ______________________________ Plan name: ____________________________

ID Number: __________________________________ Group Number (if any):____________________________

Policy Holder:______________________________ __________________________ __________ ______
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____________ Relationship to Patient____________ SS # _________________

Policy Holder Address (if different from patient):____

Home Phone#___________________ Cell Phone #___________________ Work Phone # ___________________

Initial ↓

BILLING CONSENT

______ I authorize Jefferson County Health Department (JCHD) to bill my health insurance company for services provided by the Department, and to exchange information necessary to secure payment for services rendered. Such necessary information may include diagnosis, service dates, types of services and other information related to JCHD's services necessary to process claims. I further authorize JCHD to release information for purposes of fee collection.

______ I will notify JCHD of any changes in my health insurance coverage as well as any denial information.

______ I understand that if an insurance payment is made directly to me I am responsible for immediately sending any such payments to JCHD.

______ I understand that submission of insurance information does not guarantee coverage. It is the policy holder's responsibility to know their coverage plan.

______ I understand that if the insurance company does not cover the services, I will be responsible for all payments for services rendered.

______________________________________ ____________________
Patient/Patient Representative's Signature **Date**

______________________________________ ____________________
JCHD Staff Member Signature **Date**