# Immunization Clinic Information
## *Consent Form*

Vaccine Information Statements



Weber-Morgan Health Department is offering the following immunizations:

☐ MMR (Measles, Mumps, Rubella)    ☐ Influenza (Flu)    ☐ Tdap (Tetatnus, Diphtheria, Pertussis)    ☐ COVID

- **Please fill out <u>both</u> sides of this form.**
- **Please read the Vaccine Information Statements,** which can be accessed by scanning the QR code above.

*WMHD can bill the following insurance companies; please verify that your insurance plan is in network with WMHD or pay the appropriate fees. No EPOs accepted. Not all plans are participating with Weber-Morgan Health Dept/Gregory Gochnour, MD. No international insurances accepted.*

***Subscriber/Policy Holder Name***

- Aetna *(No EPOs)*
- CHIP
- GEHA
- Medicaid
- PEHP
- TRICARE
- University of Utah

- BCBS *(No Focal Point & no EPOs)*
- Deseret Mutual
- Health Choice
- Medicare *(Part B only)*
- Samera Health *(T&C network only)*
- UMR

- BRMS *(Beyond Investments only)*
- Educators Mutual
- HealthEZ *(OSD only)*
- Molina
- SelectHealth
- United Health



***Policy/ID #***          ***Group #***
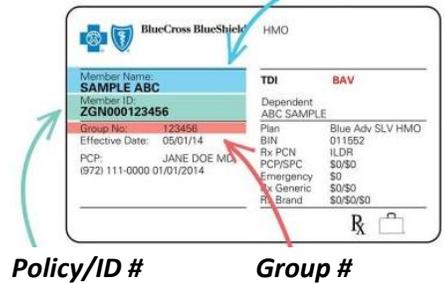
**Please choose one of the following payment categories** *(<u>ALL</u> information must be completed in order for us to bill)*
*<u>If you have more than one insurance, check **ALL** that apply. PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.</u>*

☐ 1) **Patient has one or more of the insurances listed above*** *List Medicaid/Medicare in options 2 or 3. TRICARE use 11-digit DBN)* **(W)**
Primary Insurance:_____ Policy #:_____ Group #:_____
Subscriber Name:_____ Subscriber Date of Birth: _____
Secondary Insurance: _____ Policy #:_____ Group #:_____
Subscriber Name:_____ Subscriber Date of Birth: _____

☐ 2) **The patient has*:** ☐ **Medicaid**   -or-   ☐ **CHIP**   SSN: _____   **(0-18 VFC) (19+ W)**
*Check one:* ☐ Traditional Medicaid   ☐ Health Choice   ☐ Molina   ☐ SelectHealth   ☐ University of Utah
Member ID/Medicaid #:_____   CHIP Policy # *(SelectHealth Only)*: _____

☐ 3) **The patient has*:** ☐ **Medicare (Part B)**   -or-   ☐ **Medicare Advantage Plan**   **(W)**
Medicare #:_____   ☐ Medicare Railroad   SSN: _____
Insurance Name:_____ Policy #: _____ Payer ID #: _____
Medical Claims Address: _____ City/State/Zip Code: _____

☐ 4) **The patient has NO insurance**. Please pay outreach fee.** [It is unlawful to select this option if patient has any insurance coverage]
<u>Adults (age 19+)</u>: Flu Shot $20, High Dose Flu $140, Tdap $20, MMR $20, COVID $20 **(19+ SP or W)**
<u>Children (age 0-18)</u>: Flu $20, COVID $20 **(0-18 VFC)**

☐ 5) **The patient has insurance but will be paying out of pocket because:** **(W)**
   o **the patient's insurance is NOT listed on this form**
   o **the patient's insurance does NOT cover immunizations**
   o **the patient does not wish to have insurance billed**
**Please pay self-pay fee indicated below****
<u>Adults & Children</u>: Flu $50, High Dose Flu $140, Tdap $82, MMR $142, COVID $218

***If payment is indicated, please present it with this consent form on the day of the clinic.*
**Cash or check is acceptable. Please make check payable to "WMHD".**
If you would like us to send you an itemized receipt to submit to your insurance – please call (801)399-7250.

| Patient's name: | | Gender *(circle one)*: **Female    Male** | Date of Birth: | Age: |
|---|---|---|---|---|

| Phone: | Email: | Ethnicity *(circle one)*: **Hispanic    Non-Hispanic** | Race: |
|---|---|---|---|

| Address: | City: | Zip Code: |
|---|---|---|

**The person receiving the vaccine:**                                                     YES        NO

1. has been ill in the last week with anything more severe than a cold?   ☐   ☐
2. has a serious allergy to any foods or medications? *If yes, please list:* _____   ☐   ☐
3. has had a serious reaction to a previous vaccination?   ☐   ☐
4. has a history of Guillain-Barre Syndrome or had a seizure, brain or nerve problem? *If yes, please circle.*   ☐   ☐
5. has taken antiviral medication, received a blood transfusion or immune globulin in the past year?   ☐   ☐
6. has had a vaccine in the last month? *If yes, please list vaccine(s) & date:* _____   ☐   ☐
7. is receiving aspirin therapy or medication that suppresses immune system (e.g. chemotherapy)?   ☐   ☐
8. is pregnant or breastfeeding, or could become pregnant in the next month?   ☐   ☐
9. has a blood disorder called thrombocytopenia or thrombocytopenic purpura?   ☐   ☐
10. has a parent or sibling with an immune system problem?   ☐   ☐
11. has a chronic illness such as heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g. diabetes), a spinal fluid (CSF) leak, an immunocompromising condition, missing or non-functioning spleen or a cochlear implant?   ☐   ☐
    *If yes, please circle and describe:* _____

## I WOULD LIKE TO RECEIVE THE FOLLOWING VACCINE(S) TODAY:

- **MMR (Measles, Mumps, Rubella)**   YES ☐   NO ☐          • **Influenza (Flu)**   YES ☐   NO ☐
- **Tdap (Tetanus, Diphtheria, Pertussis)**   YES ☐   NO ☐          • **COVID**   YES ☐   NO ☐

*I have read, or had explained to me, the information contained in the Vaccine Information Statement for the person receiving the vaccine(s). I understand the benefits & risks of the vaccine(s) & request that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers & others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers & agree to pay the portion not covered by my insurance. I understand that if Weber-Morgan Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred. I am hereby notified that the Weber-Morgan Health Department's Notice of Privacy Practices & Patient Responsibility Form are located at [www.webermorganhealth.gov](www.webermorganhealth.gov) & I have had a chance to ask questions. Vaccine Information Statements can be accessed by scanning the QR code on the opposite side of this form & I have had an opportunity to review these & ask questions. The Weber-Morgan Health Department collects this data in order to coordinate services. We are committed to protecting your data privacy. See [https://www.webermorganhealth.gov/about/personal-data-request-notice/](https://www.webermorganhealth.gov/about/personal-data-request-notice/)*

**Patient/Parent/Guardian Signature:** _____

*I authorize WMHD to verbally disclose my protected health information including treatment, billing, and lab results to:*

**Name/Relationship:** _____   **Phone:** _____

The Stock Used is:   **Weber** ☐      **Special Project** ☐                    Date: _____

Nurse's Initials _____

| **Vaccine:** | **Site:** | **Vaccine:** | **Site:** |
|---|---|---|---|
| ☐ **Flu PFS** ( > 6 mos) _____ [90656] ☐ L ☐ R | | ☐ **MMR** _____ [90707] ☐ L ☐ R | |
| ☐ **HD Flu** (65 +) _____ [90662] ☐ L ☐ R | | ☐ **Tdap** _____ [90715] ☐ L ☐ R | |
| ☐ **Moderna 6m-11y** _____ [91321] ☐ L ☐ R | | ☐ **Moderna 12+** _____ [91322] ☐ L ☐ R | |

**Notes:**_____

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