MERCER COUNTY
CELINA CITY
Health Department
PREVENT • PROMOTE • PROTECT

# INFLUENZA VACCINATION Insurance & Consent form

__HD Tri

__.25cc Quad

__Flu Mist

__.5cc Quad

__Initials

Patient Name:_____
Last First M.I.

Birth date: _____ Current Age:_____ Gender male female

Address_____
Street City

State:_____ Zip:_____ Phone: _____

**Select all that apply:**

**___I request MCCCHD to bill my insurance/Medicaid/Medicare**
**___I will pay cash/check at time of service**
**___I have no insurance**

**Insurance** Responsible Party Name: _____
Last Name First Name M.I.

Address: _____ City: _____

State: _____ Zip: _____ SS#: _____ Birth date:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

**Relationship to patient:** _____ **Employer name:**_____

I understand that I am responsible for all charges incurred by not providing the most current, correct insurance information to the Mercer County Celina City Health Department (MCCCHD).

I understand that I am responsible for notifying the MCCCHD if there is a change in the insurance coverage or funding status.

**Deductible:** I understand that if my insurance carrier determines that I have not met my deductible, that I will be fully responsible for payment in a timely manner. Payment will be made within 30 days of notification by my insurance carrier or Mercer County Celina City Health Department.

**I understand that I will assume full responsibility for payment for services, if my insurance denies or does not cover my claim for services rendered at Mercer County Celina City Health Department. I accept financial responsibility with or without the use of insurance coverage.**

Authorization to pay benefits to Mercer County Celina City Health Department: I authorize payment for medical services provided directly to the Mercer County Celina City Health Department.

***** No child 18 years and younger will be denied influenza vaccine because of inability to pay.**
***** We are able to bill contracted insurance carriers only if all necessary information is provided. A $15.00 fee will be charged for all returned checks*****

Signature of Responsible Party: Self, Parent or Guardian: _____

Date: _____

Payment:

Initials:

Time:_____