VaxCare

VaxCare has partnered with your healthcare provider to provide immunizations.

All bills for immunizations will come from VaxCare and its physicians.

Partner ID:
Clinic ID:
Patient ID:
Consent ID:

Partner Name:

Provider Name:

Eligibility info:

Check Complete	Active Coverage	Accepted Plan	Immun. Coverage	No Patient Resp.
√	√	√	√	√

☐ Phone Verified Eligibility

Date of Active Coverage:

PATIENT FIRST NAME (as it appears on insurance card) | MI | PATIENT LAST NAME (as it appears on insurance card) | DATE OF BIRTH (MM•DD•YYYY) | GENDER: ☐ M ☐ F

ETHNICITY: ☐ Amer. Indian / Alsk. Native ☐ Asian ☐ Black / Afr. Amer. ☐ Hawaiian / Pac. Islnd. ☐ Hispanic ☐ White ☐ Other____________

STREET ADDRESS | APT/SUITE | CITY | STATE | ZIP

HOME OR PRIMARY PHONE | LAST 4 OF SSN | GUARDIAN FIRST NAME (IF PATIENT IS A MINOR) | GUARDIAN LAST NAME

Payment and Insurance Information (Please complete only information relevant to one payment method)

PRIMARY INSURANCE NAME | MEMBER / INSURED ID# | GROUP ID

SECONDARY INSURANCE NAME | MEMBER / INSURED ID# | GROUP ID

RELATIONSHIP TO THE INSURED ☐ Self ☐ Spouse ☐ Dependent

INSURED FIRST NAME | INSURED LAST NAME | INSURED DOB (MM•DD•YYYY) | GENDER: ☐ M ☐ F

☐ SELF PAY | AMOUNT $ | PAYING CASH ☐ | PAYING CHECK ☐ | PAYING CREDIT CARD ☐

All funds for self-pay patients should be paid at the time of service and NOT remitted to VaxCare.

☐ EMPLOYER PAY | EMPLOYER NAME | EMPLOYER ID# | EMPLOYEE ID#

☐ NO PAY ☐ NP / INDIGENT ☐ PARTNER EMPLOYEE

Authorization and Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. **I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity.** In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

SIGNATURE of PATIENT or LEGAL GUARDIAN | DATE

FOR OFFICE USE ONLY - BLACK INK ONLY

Vaccination Details

☐ ActHib ☐ Gardasil ☐ Pentacel
☐ Adacel ☐ Havrix ☐ Pneumovax 23
☐ Comvax ☐ Infanrix ☐ Prevnar 13
☐ Daptacel ☐ IPOL ☐ Recombivax HB
☐ Decavac/ Tenivac ☐ Menactra ☐ Rota Teq
☐ Engerix ☐ MMR II ☐ Vaqta
☐ FluMist ☐ Ped DT ☐ Varivax
☐ FluZone ☐ Pediarix

Product Name:	LOT#	SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other____ / DELIVERY: ☐ IM ☐ SQ ☐ PO ☐ IN Other____
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ADMINISTRATOR SIGNATURE

Nurse/Administrator: I hereby attest by signature below that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Sheets and appropriate Immunization Schedules, and has given verbal and written consent for vaccination(s).

ADMINISTRATOR ID | DATE (MM•DD•YYYY)