AUGLAIZE COUNTY HEALTH DEPARTMENT
prevent. promote. protect.

Name: Last, First, MI			Date of Birth	Age
Address	City	State	Zip	County
Phone	Sex	Father's First & Last Name (if minor)	Mother's First & Last Name (if minor)	
Race	Client SS#	Father's Phone # (if minor)	Mother's Phone # (if minor)	

Select all that apply:

_____I request ACHD to bill my **Commercial Insurance Plan** (provide copy of the card)
_____I request ACHD to bill my **Medicare** or **Medicare Advantage Plan** (provide copy of the primary card)
_____I request ACHD to bill my **Medicaid Plan** (provide copy of the card)
_____I will pay cash/check at the time of service ($39 Reg/$90 Flublok/$90 HD)

	Yes	No
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barrè syndrome?	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐

- ***Authorization to pay benefits to Auglaize County Health Department (ACHD)****: I authorize payment be made directly to ACHD for medical services provided to me or my family members. I authorize the release of any medical or other information necessary to process this claim. 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 ACHD. I accept financial responsibility with or without the use of insurance coverage. I understand that I am responsible for notifying the ACHD if there is a change in the insurance coverage or funding status. I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to the ACHD.*
- ***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 ACHD*
- ***No child 18 years and younger eligible for federal vaccine will be denied influenza vaccine due to the inability to pay at the time of service***

IMMUNIZATION CONSENT

I grant permission to the Auglaize Co Health Department to give the requested vaccines to myself or the person named above for whom I am authorized to make this request. I have read or had explained to me the information from the Vaccine Information Statement (VIS) and understand the risks and benefits of this vaccine. I have received or have been offered the HIPAA Privacy Notice and the VIS.

Patient/Parent/Legal Guardian Name: _____ Date:_____

Primary Insurance	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:
Secondary Insurance (if applicable)	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

STAFF USE BELOW

		Vaccine/VIS		Date Given	Manufacture	Lot#	Injection Site	Administrator
V	P	FLU	1/31/2025		SP		LT RT LD RD	
	P	FLUBLOK	1/31/2025		SP		LT RT LD RD	
	P	HD FLU	1/31/2025		SP		LT RT LD RD	