

Mainline Pharmacy
1207 Second St
Cresson, PA 16330
814-886-5667

Adult Vaccine Consent and Administration Record
Pharmacist Immunization Program

_____ **M** or **F**
 Last Name First Name Date of Birth Sex

_____ _____
 Street City, State Zip Code Phone Number

List any known Allergies: _____

Describe or List any existing Medical Conditions: _____

Primary Care Physician: _____ Phone Number: _____

<i>Please answer the following questions:</i>	Yes	No	Don't Know
1. Are you sick today? (For example: a cold, fever, acute illness) Today's date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take anticoagulation medication?(For example: Warfarin, Coumadin or other blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please read the following statements and sign and date below.

Consent for services, HIPAA Privacy Information and Medical Records

I have been provided with the Vaccine Information Sheet (VIS) and/or been provided with information regarding to the vaccine I am receiving. I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated by this provider (standing order practitioner (Dr. _____), my Primary Care Physician (PCP), my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. This authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse or revoke this Authorization at any time. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice. I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request. For Medicare Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct. I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

Signature of patient or guardian: _____ Date: _____

This section to be completed by the Pharmacy: Vaccine Administration Information

_____ _____
Date Product Manufacturer Vol (ml) Route Site

Lot # Exp. Date VIS Version Date Date VIS Given to Pt Administering Immunizer

Patient Insurance Information: *(Copy front and back of the card)*

Primary:
 Plan Name: _____ Payer ID: _____

ID# _____ Group: _____

Secondary:
 Plan Name: _____ Payer ID: _____

ID# _____ Group: _____

Affix Rx Label Here

ELECTRONIC BILLING SERVICES, INC
138 N PRAIRIE AVE
PO BOX 2013
SIKESTON, MO 63801
FAX: (573) 472-3595
TELE: (573) 472-3613
TOLL FREE 1-888-829-3613

INFORMATION NEEDED BY E.B.S.

Immunization CLAIMS

Completed Immunization Form (one time, unless information has changed)
Copy of the patient's insurance cards

A copy of **ALL** Medicare/Medicaid/Insurance Remittance Advices (EOB's), (Primary and Secondary), should be forwarded to E.B.S. to ensure proper payment was made, and to update your accounts receivable. In some cases, EBS will download these remittances electronically and forward to you a copy (via email or fax). Clients failing to forward necessary EOB's/remittance advices to EBS will be subject to a rate increase of EBS fees.

All correspondence (requests for additional information, audits, recoupment's, etc) from insurance, Medicare, Medicaid, etc must be forward to EBS promptly. These documents generally have time limits for response.

Each month you will receive a Patient Statement for any amount owed to you by your patient. A copy of all Patient Payments must be sent to EBS to ensure that their account is properly credited.

You can receive an account summary report indicating the aging of balances, monthly billing journal and cash receipts journal, and a held orders report by logging into HDMS Mobile Reporting.

Patient Insurance Information:

Primary:

Plan Name: _____ BIN#/Condor: _____

ID# _____ Group: _____

Secondary:

Plan Name: _____ BIN#/Condor: _____

ID# _____ Group: _____