Adult Services Screening/Billing Form

☐ Salem Location: 118 Cross Creek Blvd. Salem, IL 62881 Phone:618-548-3878 ☐ Centralia Location: 1013 N Poplar Centralia, IL 62801 Phone : 618-532-6518

Last Name	First Name	MI	Date

Address	City	Zip

Phone	Sex M F	Weight	Doctor

Birthdate	Age	Previous Name

For the patient: The following questions will help us determine which vaccines you will be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated, but additional questions must be asked. If a question is not clear, please ask our immunization staff to explain it.	YES	NO	Don't Know
Is the person getting vaccinated sick today?			
Does the person have allergies to medications, food, a vaccine component, or latex?			
Has the person ever had a serious reaction after receiving a vaccine in the past?			
Does the person have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
Does the person have cancer, leukemia, HIV/AIDS, or any other immune system problem, or have a parent, brother, or sister with an immune system problem?			
In the past 6 months, has the person taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs: drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis: or had radiation treatments?			
Has the person had a seizure, or a brain or other nervous system problem?			
Has the person been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
In the past year, has the person received a transfusion of blood/blood products, or been given immune (gamma) globulin or an antiviral drug?			
Is the person pregnant or is there a chance she could become pregnant during the next month?			
Has the person to be vaccinated received any vaccinations in the past 4 weeks?			
Has the person ever felt dizzy or faint before, during, or after a shot; Or is anxious to be vaccinated today?			

If services are billed, I authorize Marion County Health Department (MCHD) to release service-related information regarding the above-mentioned to third-party payers and to bill for services rendered to the patient if applicable. I request my payer to pay MCHD directly for services rendered to the patient. **I understand I am responsible for payment in the event my third-party payer determines I am ineligible for this benefit.** By signing this form below, I acknowledge the following and certify that: I am authorized to consent for vaccination for the person named above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the requested vaccine(s) and I have received, read and/or had explained to me the appropriate information sheet(s) for the vaccine(s) I have elected. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I attest that my answers on the screening form are truthful and accurate. I acknowledge that I should remain near the vaccination location for approximately 15 minutes after vaccine administration. I authorize the data on this form to be released to I-CARE IIS database. I acknowledge the offering and/or receipt of the Notice of Privacy Practices. I fully understand all the risks and benefits of receiving vaccine(s) and consent to the administration.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____

FORM REVIEWED & IMMUNIZATIONS GIVEN BY NURSE: _____ DATE: _____

OFFICE USE ONLY BELOW THIS LINE

	PAYOR SOURCE		AMOUNT PAID		VACCINE SERVICE
	Medicaid	$			**Vaccines 317**
	Managed Care (MCO)		**Check**		**Vaccines PP**
	Molina		**Cash**		**TB Test**
	Meridian		**Receipt #:**		**Hemoglobin**
	BC Community Health Plan				
	Aetna Better Choice		**Debit/Credit Card TRANS#**		
	Youth Care				
	Private Insurance				
	Name:				

PLEASE ATTACH A COPY OF ANY/ALL INSURANCE CARDS EACH VISIT

Updated February 6, 2025