NEW HANOVER COUNTY
PUBLIC HEALTH
2029 South 17th Street, Wilmington, NC 28401
P: (910) 798-6500 | F: (910) 341-4146 | NHCgov.com
Phillip Tarte, Director

OUTREACH VACCINATION AUTHORIZATION FORM

Full Name:		**Country of Birth:**	**Date of Birth:**
Social Security Number (last four numbers):	**Preferred Language:**	**Phone Number:**	
Address:	**City:**	**State:**	**Zip code:**

Race: ☐ Asian ☐ Black/African American ☐American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐White ☐ Declined

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic ☐Declined **Gender at Birth**: ☐Male ☐Female ☐Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Declined **Homeless**: ☐Yes ☐No ☐Declined

Migrant Farm Worker: ☐Yes ☐No ☐Declined **Seasonal Farm Worker**: ☐Yes ☐No ☐Declined

Smoking Status (13 and older patients only):
☐Every day smoker ☐Some day smoker ☐Never smoker ☐Former smoker ☐Heavy tobacco smoker ☐Light tobacco smoker ☐Declined

NOTICE OF PRIVACY PRACTICES *(Please Sign and Date)*

I have received and read the appropriate Vaccine Information Statement. I understand that I may access the New Hanover County Health Department Notice of Privacy Practices by visiting http://health.nhcgov.com/?p=529 and may call 910-798-6500 to contact the privacy officer to obtain a copy or to address any concerns.

Signature: _____ **Date:** _____

Insurance Name:	**Member Id:**
Insurance Address:	**Insurance Phone:** ( )
Subscriber Name:	**Subscriber Date of Birth:**
Subscriber Address:	

I request payment of authorized 3rd Party Payer (Insurance) and Medicaid benefits made on my behalf to New Hanover County Health Department (NHCHD) for services provided. I authorize any holder of medical information regarding myself to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

I agree to repay the NHCHD any money I receive from insurance for services that the NHCHD provided for me. I further agree that failure to repay assigned insurance benefits to the NHCHD may be reason for denial or restriction of future services until such amounts have been repaid. I understand fees for services submitted to Medicaid, Medicare, or third party insurance which are determined to be non-covered, applied to my deductible or co-insurance are my responsibility. I understand the following services may be non-covered.

I understand that my signature will serve as legal "signature on file" for purposes of filing my Insurance/Medicaid claims and payment of benefits to the NHCHD for services rendered.

Signature: _____ **Date:** _____

Vaccine	Vaccine Fee	Admin Fee	Total Fee
90685: Influenza Preservative-Free 6-35 Months	$20.00	$25.00	$45.00
90686: Influenza Preservative-Free 3 years and older	$20.00	$25.00	$45.00
90662: High Dose/Ages 65 years and older	$35.00	$25.00	$60.00
90688: Regular Influenza (Quadrivalent)	$20.00	$25.00	$45.00
90682 Flublok Quadrivalent 18 years and older	$20.00	$25.00	$45.00

❒ STATE **90686 Influenza Preservative Free, 6 months and up** **LOT#** _____	❒ PRIVATE _____ **90686 Influenza Preservative Free, 6 months and up** _____ **90688 Influenza Regular (Quadrivalent)** _____ **90662 High Dose** _____ **90682 Flublok Quadrivalent 18 years and older** **LOT#** _____
Provider (Nurse) Sign & Date	Keyed by: