DRIVE THRU FLU SHOT CONSENT

An Affiliate of MERCYONE

PATIENT NAME:_________________________ DATE OF BIRTH:_________________________

PHONE: _________________________ SOCIAL SECURITY#:_________________________

I, the above referenced patient or legal representative for the above referenced patient ("Patient") am presenting for the testing service above from Mount Ayr Medical Clinic/Ringgold County Hospital.

FINANCIAL AGREEMENT. I consent to the billing of the attached identified insurer and/or third party for payment of the elected testing service and authorize/consent to Provider releasing information necessary to such insurer or identified third party for payment. By signing this consent form, I agree to be responsible for any amounts not covered by insurance and understand my provider is making no representation to me that the services provided will be covered by my insurer.

RELEASE OF INFORMATION/RIGHTS & RESPONSIBILITIES. All requests for information are subject to federal and state confidentiality laws and regulations. I understand Provider will communicate test results to Iowa Department of Public Health as required by law. The provider complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender or sexual orientation. Language assistance services are available to patients with limited English proficiency or other communication needs.

ASSUMPTION OF RISK & RELEASE. I recognize that there are certain inherent risks associated with drive through influenza vaccine administration. I hereby consent for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily agree to have my influenza vaccine administration and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my participation in this activity, and do hereby release and forever discharge the provider, and its affiliates, managers, directors, officers, employees, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, economical or emotional loss, that I may suffer as a direct result of my participation in this activity, including traveling to and from any location related to this activity

INDEMNIFICATION. I agree to indemnify and hold harmless provider, and its affiliates, managers, directors, employees, officers, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf.

UNIFORM ASSIGNMENT. I hereby assign, transfer and set over to Ringgold County Hospital and treating physician(s) sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to me or my dependent at Ringgold County Hospital. It is understood this release does not relieve me of financial liability for payment of all balances due. I understand that I am responsible for payment of all charges for services not covered by insurance policy benefit plan for me or my dependent.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS DOCUMENT. I UNDERSTAND AND VOLUNTARILY ACCEPT ITS TERMS. IF I AM SIGNING FOR SOMEONE ELSE, I REPRESENT I HAVE THE LEGAL AUTHORITY TO DO SO.

_________________________ _________________________
Signature of Patient or Legal Representative Date

_________________________ _________________________
Printed Name of Legal Representative, if applicable Relationship, if appliable

An Affiliate of MERCYONE

DATE: ___________________

PATIENT INFORMATION Please print in blue or black ink

Patient Name: ______________________ ______________________ _________ ☐ Male ☐ Female
Last First MI

DOB: ____________________ Age: ______________ Social Security # ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Declined
Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Address: ____Apt # _________ City_________________ St___________ Zip __________

Phone: Home_____________________________Cell______________________________ Work_______________________________

Employer: ____ Emergency Contact: ____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, or if patient is a minor, please complete section below)*

Name: Last________________________________ First____________________________ MI_________ ☐ Male ☐ Female

DOB: __________________ Relationship: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (Please Specify): _________________________

Address: ____Apt #___________ City____________________St_______Zip ___________

Phone: Home__________________________ Cell______________________________ Work________________________________

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID
You will be asked to present your insurance card(s) at each visit so that we can confirm that billing information remains current.

INSURANCE INFORMATION

Primary Insurance______________________________ ID ______________________________________ Group: _____________________

Policy Holder Name:____________________________________ Relationship (Circle One) Self Spouse Parent Other _______________________

SS#_____________________________ Policy Holder's DOB_________________________ Employer_______________________________________

Secondary Insurance____________________________ ID: _____________________________________ Group ______________________

Policy Holder Name:____________________________________ Relationship (Circle One) Self Spouse Parent Other _______________________

SS#_____________________________ Policy Holder's DOB_________________________ Employer_______________________________________