vaxcare Vaccine Consent Form

Cooper Co. Public Health Center
12040 Klinton Drive
Boonville, MO 65233

VaxCare has partnered with your healthcare provider to provide immunizations. All listed vaccines will come from VaxCare and its physicians.

Clinic Info

Partner / Clinic Name

Date of Service

Payment & Patient Info

Patient Name | Date of Birth | Gender | Phone

Address | Social Security #

Payer Name | Member ID | Group ID

Insured Name | Insured Date of Birth | Ins. Gender | Relation to Insured

Payment Type | Credit Card Number | Expiration Date | CVV Code

Notes

Check Out Doses

Check out and scan all ordered doses on the VaxCare Hub by the end of day.

Vaccine	Lot #	Site (LD LL RD RL)	Route (IM SQ IN PO)	Vaccine	Lot #	Site (LD LL RD RL)	Route (IM SQ IN PO)

Administrator Name | Administrator Signature | Administration Date

Collect Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association.

Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

Patient Signature | Date