Wyandot County Public Health
Covid-19 Administration Record
Patient Financial Responsibility Form

PLEASE PRINT CLEARLY

Last Name	First Name	M.I.

Address	City	State	Zip

Phone Number	Parent/Guardian Name (only if client is under age 18)

Birth Date	Age	Sex Male Female

Please answer the questions below:

Are you pregnant or breastfeeding?	Yes	No
Are you allergic to polyethelene glycol or any other components of the vaccine?	Yes	No
Have you ever had a reaction from a vaccine or injectable medication in the past?	Yes	No
Do you currently have Covid-19	Yes	No

I have read or have had explained to me the information regarding Covid-19 disease and the Covid-19 vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. I believe I understand the benefits and risk of the Covid-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature is also agreement to provide payment of all charges at the time of service.

Patient or Guardian Signature________________________________

Date Signed________________________________

For Office Use Only

	INSURANCE	**SELF-PAY**
	Medicare (Traditional Part B) ID#__________	☐ Cash
	Medicare HMO (ex. Anthem Medicare Advantage, Aetna Medicare Advantage)	☐ Check #__________
	Name of plan:__________ ID#__________	☐ Credit Card
	Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Paramount)	Type__________
	Name of plan:__________ ID#__________	CC#__________
	Private Insurance Company Name__________	Exp. Date__________
	Member ID:__________Group:__________Plan:__________	Amount:__________
	Policy Holder Name & Date of Birth:__________ ___/___/___	Receipt #__________
	Relationship to Policy Holder:__________	Received by:__________

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Vaccine Administered Information

Date	Vaccine Name	Vaccine Lot #	Exp. Date	Mfg.	IM Site	Dose	Staff initials
						0.5 ml	
Initial Dose	Booster Dose				VIS:		