

Chaffee County Public Health

Patient Billing Sheet

Adult

448 East 1st Street Suite 137
 Salida, CO 81201
 Phone: 719-539-4510 Fax: 719-539-7197

Medicaid:	ID#
CCHP/CHP+	ID#
	Group
CO Access	ID#
	Group

Date of Service:				
Client Name:		Gender:	Age:	DOB:
Address:			Phone:	
City:	State:	Zip:	EMAIL for future IZ reminders:	

Vaccine/Service	CPT	ICD	VFC/317/PP	Lot #	Exp. Date	Site	Fee	Discussed/Refused
Dtap	90700	Z23					50.00	
Dt	90702	Z23					70.00	
Hepatitis A: ADULT	2 Dose	90632	Z23				95.00	
Hepatitis A (Ped/Adol.)		90633	Z23				50.00	
Hepatitis B: ADULT	3 Dose	90746	Z23				70.00	
Hepatitis B (Ped/Adol.)		90744	Z23				45.00	
HIB		90648	Z23				50.00	
HPV (Gardasil 9) (3 dose)		90651	Z23				200.00	
Influenza = or > 36 mths	Quad	90688	Z23				N/A	
PF Influenza = or > 36 mths	Quad	90686	Z23				N/A	
Influenza = or > 36 mths	Tri	90658	Z23				N/A	
PF Influenza = or > 36 mths	Tri	90656	Z23				N/A	
Intradermal Influenza (18-64 yrs)	Quad	90630	Z23				N/A	
Influenza High Dose (65+)	Quad	90662	Z23				N/A	
Influenza < 36 mths	Quad	90687	Z23				N/A	
PF Influenza < 36 mths	Quad	90685	Z23				N/A	
Kinrix (Dtap/IPV)		90696	Z23				75.00	
Meningococcal (Menactra)		90734	Z23				135.00	
Meningoccal Type B (10-25 yrs)	2 Dose	90620	Z23				185.00	
MMR		90707	Z23				90.00	
MMRV (MMR, Varicella)		90710	Z23				200.00	
Pediarix (Dtap, IPV, Hep B)		90723	Z23				95.00	
Pentacel (Dtap, IPV, HIB)		90698	Z23				90.00	
Prevnar 13		90670	Z23				185.00	
Pneumovax 23		90732	Z23				105.00	
Polio (IPV)		90713	Z23				55.00	
Rotavirus: Rotateq Oral (3 dose)	3 Dose	90680	Z23				105.00	
Td		90714	Z23				50.00	
Tdap		90715	Z23				60.00	
Twinrix (Hep A/B) (3 dose)		90636	Z23				115.00	
Varicella		90716	Z23				135.00	
Zostavax		90736	Z23				220.00	
Other:								
Japanese Encephalitis	2 Dose	90738	Z23				310.00	
Rabies	3 Dose	90675	Z23				340.00	
Typhoid (Oral)		90690	Z23				130.00	
Typhoid (Inj.)		90691	Z23				135.00	
Yellow Fever		90717	Z23				195.00	

Amount Client Owes Today:

Amount Billed to Insurance:

Signature of Vaccine/Screening Administrator

Date of Administration

Comments

Screening Questionnaire

	Yes	No	Unknown
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an allergy to any food, eggs, latex or to a vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to any vaccine or intranasal flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long term health problem like: heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, diabetes, anemia or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 3 months have you taken medications that weaken your immune systems such as cortisone, prednisone, other steroids, anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been receiving anti-viral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been diagnosed with Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g. isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had a seizure or a brain/other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

_____ RN

Release of Information/Consent for Services/Assignment of Benefits Statement

I have read or have had it explained to me information about the vaccines and/or services to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of these vaccines and/or services and ask that they be administered to me or to the person named previously, for whom I am authorized to make this request. I also acknowledge that I have been offered copies of the appropriate Vaccine Information Statements (VIS) if applicable.

I am aware that I am responsible for all fees for immunizations and services provided to me or for those who are my dependents. I also understand that payment is due at the time of service unless arrangements for insurance billing or private billing are made and authorized by Chaffee County Public Health personnel.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Chaffee County Public Health for the medical services rendered to myself or my dependents. I understand that I may be responsible for any amount not covered by insurance.

I hereby authorize Chaffee County Public Health to release any necessary information to insurance carriers needed in order to obtain payment. I am aware that this consent will remain in effect for one full year from the date of signature unless cancelled in writing.

I acknowledge that I have been offered a copy of the Chaffee County Public health Notice of Privacy Practices.

Patient's Signature _____

Date _____

Staff's Signature _____

Date _____