

# Adult Registration and Medical Release

<b>Client Name</b> _____ <small>(Exactly as appears on Medicare/Insurance card)</small>	<b>Date of Birth</b> _____
<b>Address</b> _____	<b>Apt No.</b> _____
<b>City</b> _____ <b>ZIP</b> _____	<b>Phone</b> _____
<b>Social Security Number</b> _____	<b>Race</b> _____ <b>Sex</b> _____

**Services Requested**

I request the following vaccination(s) from the Pinellas County Health Department:  Influenza (flu shot)

**Health Insurance**

Medicare B - **Medicare Policy Number (copy from card if applicable):** \_\_\_\_\_

HMO/Other Insurance                       DOH Employee                       None

**I have requested vaccination services** from the Pinellas County Health Department as indicated above. I have received and understand information provided in the Vaccine Information Statements.

**Medicare Patient Certification, Authorization To Release and Payment Request** – As client/representative signed below, I certify that the information I have given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the Pinellas County Health Department to release protected health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the Pinellas County Health Department and authorize it to submit a claim to Medicare for payment.

**Assignment of Benefits (only applies to third party payers)** – As Client/Representative signed below, I, assign to the Pinellas County Health Department all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to the above agency. **I am personally responsible for charges not covered by this assignment.**

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

-OR-

Name of Legal Representative \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Signature of Legal Representative \_\_\_\_\_

Witness Name \_\_\_\_\_ Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## – OFFICE USE ONLY –

<input type="checkbox"/> Influenza (Flu 3Y+ PF)	Lot # _____	<b><u>Time Stamps</u></b>
<input type="checkbox"/> High Dose Influenza (65y+)	Mfg _____ Init _____	Form Check/Triage: _____
<input type="checkbox"/> Intradermal Influenza (Flu ID)	Route _____ Site _____	Dispensing: _____
<input type="checkbox"/> Flu Mist (Nasal spray)	# of people in car getting shots: _____	Checkout: _____