TRAVEL MEDICINE PATIENT DEMOGRAPHICS

Patient's Full Name: _____ DOB:_____ Sex:_____

Address: _____

Home Phone: _____ Cell: _____ Email:_____

Preferred Pharmacy Name:_____Pharmacy Phone: _____

Emergency Contact: _____Relation:_____

Address: _____Phone:_____

Primary Care Physician:_____

PCP Address:_____

PCP Phone: _____ PCP Fax: _____

HIPAA PRIVACY CONSENT

By initialing below the above named patient or the guardian of the patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a "Notice of Privacy Practices" document and the patient/guardian has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices at any time
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Initials: _____ Date: _____

FINANCIAL POLICY

By initialing below I attest that I understand and agree to the following regarding fees for services provided by the Travel Clinic:

- **A deposit of $25 will be charged prior to any consultation as payment and will be refunded upon receipt of vaccinations and/or medications purchased at the pharmacy for intended travel. Please provide credit card information below or provide check with completed travel forms.**
- Total claims/fees for services provided by the Travel Clinic are to be paid in full at time of services rendered.
- The Travel Clinic will submit claims/fees for services provided to health insurance carriers. If insurance reimbursement is less than cost of medications/immunizations plus administration fees, then the patient will be responsible to make up the difference.

Initials: _____ Date: _____

Cardholder Name: _____

Type of Card: _____

Credit Card Number: _____

Expiration Date: _____

CCV Code: _____

Zip Code: _____

DOCUMENT CONTINUED ON NEXT PAGE

INSURANCE INFORMATION

Name of Insurance: _____

Cardholder name: _____

Prescription or Member **ID** number: _____

Prescription **Rx BIN** number: _____

Prescription **Rx Group** number: _____

Prescription **Rx PCN** number: _____

REFUSAL OF RECOMMENDED IMMUNIZATIONS

By initialing bellowing I attest that I understand the risks and benefits of the immunizations that were recommended to me by the Travel Clinic. I understand that vaccination/immunizations from illness or disease is voluntary. For any reason, if I chose not to accept the recommended immunizations, I do not hold the Travel Clinic or any of its personnel accountable for any risks incurred for being unvaccinated and unprotected from potential illness or disease.

Initials: _____ Date: _____

CONSENT TO TREAT

I understand the interactions, allergies, warnings, precautions, and potential adverse reactions regarding the medications and immunizations that I received at the Travel clinic. I have read the information on the vaccine information statement sheet (VIS from the CDC) and understand the information. I voluntarily consent to receive the medications and/or immunizations.

By signing below, I hereby consent to evaluation, testing and treatment for me or the above named patient as directed by the physician or his or her designee at the Travel Clinic. By signing below, I certify I have read and understand and agree to the content on this page including the HIPAA PRIVACY CONSENT, FINANCIAL POLICY, REFUSAL OF RECOMMENDED IMMUNIZATIONS, AND CONSENT TO TREAT.

Signed: _____ Date:_____

This form/consent was signed by (Printed name): _____

Relationship of the person who signed for the patient: _____

Witness from Travel Clinic: (Print, Sign, Date): _____