



Travel & Immunization Clinic of Portland

International Travel Medical Questionnaire

NAME: _____ Birth date: _____: Gender M/F
Last First Month/Day/Year Circle One

ADDRESS: _____
City State Zip code

DAYTIME PHONE: _____ EVENING PHONE: _____

How did you hear about us:

Internet Search Phone Book Friend Referred by Doctor Other: _____

Emergency Contact:

Primary care physician: _____
Name Phone Relationship to Patient

Current medical problems: _____

Is your immune system suppressed (cancer, leukemia, HIV, other?)	Yes	No
Are you pregnant or planning to become pregnant?	Yes	No
Do you take steroids (Prednisone or other)?	Yes	No
Do you have any known allergies?	Yes	No

If you have allergies, please list:

Known allergies: _____

Current Medications: _____

Have you ever fainted from having your blood drawn or from an injection?	Yes	No
Have you ever had a bad reaction or side effect from any vaccination?	Yes	No

If yes, describe: _____

Do you live or work closely with anyone who has AIDS, an AIDS-like condition, any other immune disorder or who is on chemotherapy for cancer?	Yes	No
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Have you received immune globulin/any blood product during the past year?	Yes	No
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Have you received any vaccines in the last month?	Yes	No
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Do you have thrombocytopenia (low platelet count) or a coagulation disorder?	Yes	No
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Have you ever had a convulsion, seizure, epilepsy or neurologic condition?	Yes	No
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Have you ever had hepatitis or yellow jaundice?	Yes	No
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Have you ever had a thymus disorder or dysfunction, including myasthenia gravis, thymoma, thymectomy, or DiGeorge syndrome?	Yes	No
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Do you have a medical condition that may recur while traveling?	Yes	No
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Are you feeling sick today?	Yes	No
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Have you had a fever in the past 48 hours?	Yes	No
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What concerns would you like to discuss with the Travel Clinician today?



Travel & Immunization Clinic of Portland

Patient Responsibility:

Patients are responsible for all charges resulting from treatment provided by Portland Travel and Immunization Clinic. Payment is due in full at time of service.

☞ The price of an office visit is \$49.00.

-You will be charged:
for the office visit.
for each vaccine you receive.
and an injection fee for each vaccine we administer to you.

☞ Minors: Payments for Patients under 18 years of age will be the responsibility of the custodial parent(s).

Billing Errors:

☞ Invoices presented at time of service are preliminary bills and are subject to audit. Balance due must be paid within 10 (ten) days. Credits will be applied to your account or refunded.

Insurance Billings:

☞ We do not bill insurance.
☞ Medicare: We do not bill Medicare.

Appointment Cancellation: We require 24 hours notice for appointment cancellations and rescheduling. If you cancel or reschedule without 24 hours notice you will be billed for the missed appointment. We do not accept cancellations or rescheduling via email or voicemail. You must speak with a staff member to authorize the cancellation or to reschedule.

Authorization to Release Information:

I have read and accept this credit/financial policy for my treatment with Travel and Immunization Clinic of Portland.

If I have been referred by, or am being referred to, another healthcare provider, I authorize my provider or my provider's staff to release my clinical information to this provider for continuing care.

I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances are due at time of service.

I, or my appointed agent, have read, fully understand and agree to the above statements. I have received a copy of this information (upon request).

Patient Signature (if under 18, parent of guardian)

Date

Printed name of individual receiving vaccinations



Travel & Immunization Clinic of Portland

Patient Rights and Responsibilities

- ❖ It is your responsibility to provide us with the information needed to accurately assess your needs. This includes having specific geographic knowledge of all locations in your itinerary.
- ❖ It is your responsibility to tell the clinician the exact number of days you will be in each location on your itinerary. The clinician will review your itinerary locations, but will rely on you to provide them with the number of days in each location. **WE WILL NOT REVIEW YOUR DATES OF TRAVEL**, but instead will rely on you to provide that information.
- ❖ While we understand that sometimes your exact itinerary may be vague or unknown, failure to provide us with accurate itinerary information can put you at risk for life threatening illnesses. In some cases it may be necessary for you to have an additional consultation closer to your date of departure. Any additional costs that arise from incomplete itinerary information (i.e. changes to prescriptions or additional consultations) are the sole responsibility of the patient.
- ❖ A Yellow Fever vaccine may be required on some visa applications, or to participate in some travel abroad programs. The Yellow Fever vaccine is the **ONLY** vaccine required for entry by foreign governments at this time. This requirement is intended to keep their countries free of disease, **NOT** to keep you healthy. All other vaccines may be recommended, but will not be required for entry into a foreign country.
- ❖ Vaccine recommendations are based on several factors, with the ultimate goal of keeping you healthy. As a patient you have the right to refuse any vaccines you do not wish to receive.
- ❖ You are responsible for payment of vaccines once they are drawn up. If you choose not to receive a vaccine after it has been drawn up, you are still responsible for payment of the vaccine.
- ❖ There are two types of Typhoid vaccine (oral or injectable), in most cases our clinicians will recommend the injectable. If you prefer to have the oral, it is your responsibility to make your preference known to your clinician.
- ❖ A new consultation is required for each trip. This is necessary because health risks need to be evaluated for each destination. Even if you are traveling to a country that you have been to in the past, the risks may have changed.
- ❖ We will prescribe the medications that best meet your medical needs. We are unable to pre-authorize medications with your insurance. If cost of medications is a concern for you, it is important to discuss that with your clinician.
- ❖ With few exceptions, prescriptions are **NOT** refillable. If you need a new prescription you need to come in for a new consultation, even if you have been prescribed that same medication by one of our clinicians for a previous trip.
- ❖ **By signing this I am acknowledging that I have read and understand my rights and responsibilities as a patient of The Travel and Immunization Clinic of Portland.**

Patient Signature (if under 18, parent of guardian)

Date

Printed name of individual receiving vaccinations



Travel & Immunization Clinic of Portland

Vaccination Consent Form

Please mark all that apply

- | | |
|---|---|
| <input type="checkbox"/> I am currently pregnant | <input type="checkbox"/> I am allergic to eggs |
| <input type="checkbox"/> I am allergic to neomycin | <input type="checkbox"/> I am allergic to streptomycin |
| <input type="checkbox"/> I am allergic to sulfa drugs | <input type="checkbox"/> I am currently breast feeding |
| <input type="checkbox"/> I am allergic to mercury / thimerisol | <input type="checkbox"/> I have an immune deficiency |
| <input type="checkbox"/> I am currently being treated for a malignant disease | <input type="checkbox"/> I am currently on high dose steroids |

I understand and consent to receive the vaccinations that I approve during my consultation. I understand that receiving these injections does not guarantee that I will not become infected by an illness while I am traveling, or guarantee health in any way. Further, I understand that none of the vaccinations I am being given are 100% effective in preventing the diseases, which they are designed to prevent.

I understand that vaccinations have potential side effects including death in rare cases. I acknowledge that I have discussed the risks and side effects of these vaccines with a Travel & Immunization Clinic of Portland representative and fully understand the risks of each vaccine I have agreed to receive.

I understand that various countries change their vaccination requirements for entry into their borders. While Travel & Immunization Clinic of Portland does receive frequent updates on the constantly changing vaccination requirements for most countries of the world, I acknowledge and agree not to hold Travel & Immunization Clinic of Portland or any of its agents liable if I am denied entry into or am placed in quarantine in any country to which I am traveling. Further, I understand my travel vaccinations were determined, in part, by the travel itinerary which I provided to Travel & Immunization Clinic of Portland, and that any changes to my travel itinerary may completely change the immunizations required to enter any country to which I may be traveling.

I understand that Travel & Immunization Clinic of Portland is providing me with travel vaccinations only and that I am responsible for any medical costs associated with treatment of reactions to vaccinations as well as any medical costs associated with treatment of any illness acquired while traveling or at home.

(Your signature below indicates that you have read and agree with all items printed above.)

Patient Signature (if under 18, parent of guardian)

Date

Printed name of individual receiving vaccinations

____/____/_____
Birth date