Dorin Kemmerle, MD LLC dba Sprout Pediatrics
4350 Commercial St SE, Salem, OR 97302
(503) 877-4485 (888) 977-1263
SproutPediatrics.org

Immunizations Only Patient Registration & Consent

I request Sprout Pediatrics administer vaccines to:

Patient's legal name: _____ Date of birth: ____/____/____ Gender: M F

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Address: _____ City: _____ Zip: _____

Parent phone: _____

Health Insurance company & plan**:** _____

Subscriber: _____ ID number: _____ Group number: _____

I have requested medical services from Sprout Pediatrics and understand that by making this request, I become fully financially responsible for all charges incurred. All professional services rendered are charged to the patient and are due at the time of service. If these services are covered by health insurance, Sprout Pediatrics is a participating provider, and the insurance company verifies coverage, then only the copay, coinsurance and/or deductible are due at the time of service. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Sprout Pediatrics for medical services rendered. I understand that I am responsible for any amount not covered by insurance.

I also authorize Sprout Pediatrics to release health information as necessary to process insurance claims for care performed by our clinic, to coordinate care with my Primary Care Provider (PCP) & state vaccine registries, and as required by law. I acknowledge that Sprout Pediatrics has made available to me its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed pursuant to HIPAA, and how I can access this information. I understand that that I am entitled to receive updates upon request if Sprout Pediatrics amends or changes its Notice of Privacy Practices in a material way, and may contact them with any questions.

Date of First Service: _____/_____/_____ ☐ **Ongoing**

Service(s) to be provided: Vaccinations according to ACP Recommended Immunization Schedule

I certify that I have been provided the CDC VISs and additional information pertinent to the vaccines recommended and given the opportunity to ask questions. All vaccines administered were given with my express permission after having received all the information and answers I requested and chosen the shots to be given from Dr. Kemmerle's recommendations. Initials: ☐

I understand that I am not registering as a patient or for Sprout Pediatrics to become my PCP. After the procedure I will be given care instructions verbally and in writing, and if I have questions or concerns specific to the procedure I will call Sprout at (503) 877-4485. For any other questions or concerns I will contact my PCP.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Patient/Responsible Printed Name Relationship to patient(s)