COVID-19 Vaccination Agreement

Recipient's Full Name: _____ Date of Birth: _____

1. I have requested the COVID-19 vaccination for my child/myself.

2. The doctor has explained risks and benefits and through shared decision making, I wish to proceed with vaccination.

3. I acknowledge that my health insurance plan may not pay for this immunization due to non-coverage or application of a deductible, copayment, or coinsurance.

4. In the event that the cost of the immunization and/or the administration fee is not paid due to any of the above reasons, I will be billed by Mesquite Pediatrics and agree to pay upon receipt of the bill. The following cost is an estimate, and I understand that the allowable amount may be slightly higher or lower:

5 yr-11 yr	$ 86	VFC (AHCCCS & Self Pay Patients)
12+ yrs	$161	$20 per vaccination

5. In the event that my insurance policy does not cover the immunization, it will be my responsibility to contact my insurance carrier to appeal the decision if I would like to be reimbursed. If my insurance then agrees to pay Mesquite Pediatrics for the cost, I understand that I will be refunded only AFTER the insurance payment has been processed by Mesquite Pediatrics.

6. I understand that if I later change my mind and decide not to have my child or family member receive this immunization after it has already been made ready for administration, I will still be responsible to pay for the immunization.

By signing below, I acknowledge that I have read and understand the terms of this Agreement and agree to be bound by them.

Signature: _____ Date: _____

Printed name of parent/guardian/responsible party_____