



### CONSENT FOR TREATMENT INFLUENZA SHOT

✓ Please make checks payable to Front Range Flu Shots, LLC or FRFS.

Please Print

Last Name				First Name				Middle Initial
Date of Birth	MM	DD	YY	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Phone Number ( )	

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Billing:** Please answer all questions below. Note: Medicare Part B will pay for your flu shot only if it is your primary insurance.

1.) Medicare Part B is my primary insurance plan:  Yes  No

2.) Kaiser members must pay by cash or check. Do you have Kaiser insurance?  Yes  No

3.) Print Name exactly as it appears on insurance card: \_\_\_\_\_

Douglas County School District Cigna    Member Id #    U \_\_\_\_\_

Rocky Mountain Health Plans    Member Id #    \_\_\_\_\_ - \_\_\_\_\_

Medicare Part B    Member Id #    # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ letter(s) \_\_\_\_\_

Railroad Medicare Part B    Member Id #    letter(s) \_\_\_\_\_ # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other Medicare Advantage Plan:    Member Id #    \_\_\_\_\_

\_\_\_\_\_ Claim Address \_\_\_\_\_

If you have Cofinity insurance, your flu vaccination may not be fully covered; you are responsible for any unpaid portion.

\*Cofinity: Copay due at time of service.    Member Id #    \_\_\_\_\_

Co pay: \$ \_\_\_\_\_

**Please answer each of the following questions:**

- |  |     |    |
|--|-----|----|
| 1. Have you ever had a flu shot before?  | Yes | No |
| 2. Have you ever had an adverse reaction to a flu shot?  | Yes | No |
| 3. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein?             | Yes | No |
| 4. Have you ever had an allergic reaction to any component of the vaccine, including thimerosal?   | Yes | No |
| Describe: _____  |     |    |
| 5. Do you currently have a fever, or moderate or severe acute illness with or without fever?       | Yes | No |
| 6. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? | Yes | No |
| 7. Have you ever had a bad reaction to any other vaccine? Describe: _____                          | Yes | No |

★ I have received the *Inactivated Influenza Vaccine Information Statement*. I have read or have had explained to me the information. I have had an opportunity to review *FRFS's Notice of Privacy Practices* and am aware that I can request a copy. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the vaccine.

★ I understand that I am responsible for payment to Front Range Flu Shots, LLC if vaccination is not fully covered by insurance company.

★ I understand there is a \$25 fee for returned checks.

Signature of Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

Community Provider / HMO Use	Do not write below this line.
Federal Tax ID: 743077363	<b>INFLUENZA VACCINE</b> <hr/> Injection site:                      Nurse's Initials _____ ____ 0.50 ml Left Deltoid                      Date _____ ____ 0.50 ml Right Deltoid ____ 0.50 ml Left Vastus Lateralis                      Mfg (Circle one) <b>Sanofi / Novartis / GSK</b> ____ 0.50 ml Right Vastus Lateralis                      Lot # _____
Service Location: 11	
Diagnosis Code: V04.81	
Procedure Code: 90658	
Administration Code: G0008	
RMHP Administration Code: 90471	
Charge: \$	
Clinic Location:	