Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

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	☐ Male	☐ 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.) I have Medicare and an additional insurance plan: ☐ Yes ☐ No
2.) Medicare Part B is my primary insurance plan: ☐ Yes ☐ No
3.) Medicare members enrolled in a HMO must pay by cash or check. Do you have HMO insurance? ☐ Yes ☐ No
4.) Kaiser members must pay by cash or check. Do you have Kaiser insurance? ☐ Yes ☐ No

Please provide all information that applies:

Print Name exactly as it appears on insurance card:_____

☐ Medicare Advantage Plan: Member Id # _____

_____ Medical Claim Address: _____

☐ Medicare Part B Member Id # # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ letter(s) ___ ___

☐ Railroad Medicare Part B Member Id # letter(s) ___ ___ # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Cofinity Member Id # _____

☐ Douglas County School District Cigna Member Id # 779 ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ Rocky Mountain Health Plans Member Id # ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___

Please answer each of the following questions and sign and date below:

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:** _____

Insurance Coding Information	
Federal Tax ID:	743077363
Service Location:	11
Diagnosis Code:	V04.81
Procedure Code:	90658
Administration Code:	G0008
RMHP Administration Code:	90471
Charge:	$
Clinic Location:	

Do not write below this line.

INFLUENZA VACCINE

Injection site:
____0.50 ml Left Deltoid
____0.50 ml Right Deltoid
__0.50 ml Left Vastus Lateralis
__0.50 ml Right Vastus Lateralis

Nurse's Initials _____
Date _____
Mfg *(Circle one)* Sanofi / Novartis / GSK
Lot # _____

Front Range Flu Shots, LLC ▲ P.O. Box 1093, Littleton, CO 80160-1093 ▲ 303-797-3396 08-31-10

MED ADV / MC / RRMC / Cofinity / DCSD / RMHP / HD / Comp / Invoice / Check _____ / Cash _____