Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

DCSD Cigna / MC / RRMC / Cofinity / Other / Invoice / Check _____ / Cash _____

CONSENT FOR TREATMENT: PNEUMOCOCCAL VACCINE POLYVALENT

Must be 18 years or older to receive a pneumococcal vaccine.

✓ 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 vaccination only if it is your primary insurance.

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

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

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

4.) Print Name exactly as it appears on insurance card:_____

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

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

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

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

☐ *Cofinity: Copay due at time of service. Copay: $_____ Member Id # _____

☐ Other _____ Member Id # _____

Please answer each of the following questions:

1. Have you ever had a pneumococcal shot before? If so, when? _____	Yes	No
2. Have you ever had an adverse reaction to a pneumococcal shot?	Yes	No
3. Do you have any hypersensitivity to any component of the vaccine, including phenol?	Yes	No
4. Do you currently have a fever, acute respiratory illness or any other active infection or illness?	Yes	No
5. Are you receiving chemotherapy, radiation therapy, or any other immunosuppressive therapy?	Yes	No
6. Are you pregnant or breastfeeding? (If so, you cannot receive a pneumococcal shot.)	Yes	No

★ I have received the *Pneumococcal Polysaccharide 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 pneumococcal or any other respiratory diseases or suffer any adverse reaction following administration of the vaccine.

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

Signature of Responsible Person: _____ *Date*: _____

Community Provider / HMO Use Only

Federal Tax ID:	743077363
Service Location:	11
Diagnosis Code:	V03.82
Procedure Code:	90732
Administration code:	G0009
Customer Charge:	$
Clinic Location:	

Do not write below this section

Pneumococcal Vaccine Polyvalent

Injection site:
___0.50 ml Left Deltoid
___0.50 ml Right Deltoid

Nurse's Initials _____

Date _____

Mfg Merck

Lot # _____