

**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

<b>Last Name</b>				<b>First Name</b>				<b>Middle Initial</b>			
<b>Date of Birth</b>	MM	DD	YY	<b>Age</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<b>Phone Number (    )</b>				
<b>Address: Street</b>					<b>City</b>			<b>State</b>		<b>Zip</b>	

**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.) Medicare members enrolled in a HMO must pay by cash or check. Do you have HMO insurance?  Yes  No

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

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

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

<input type="checkbox"/> Medicare Part B	Member Id #	# _____ - _____ - _____	letter(s) _____
<input type="checkbox"/> Railroad Medicare Part B	Member Id #	letter(s) _____ # _____ - _____ - _____	
<input type="checkbox"/> Cofinity	Member Id #	_____	
<input type="checkbox"/> Douglas County School District Cigna	Member Id #	779 _____	
<input type="checkbox"/> Rocky Mountain Health Plans	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 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	Do not write below this section	
	<b>Pneumococcal Vaccine Polyvalent</b>	
Federal Tax ID: 743077363	Injection site: _____	Nurse's Initials _____
Service Location: 11	___0.50 ml Left Deltoid	Date _____
Diagnosis Code: V03.82	___0.50 ml Right Deltoid	Mfg _____
Procedure Code: 90732		<b>Merck</b>
Administration code: G0009		Lot # _____
Customer Charge: \$		
Clinic Location: _____		