

CONSENT FOR TREATMENT INFLUENZA Immunization ✓ Please make checks payable to Front Range Flu Shots, LLC or FRES.

__ Cash _____ Invoice__

Zip Code 8.26.18

Security Code

Exp. Date

Quadrivalent Quadrivalent Shot Flucelvax Shot Dose Shot Dose Shot Colored Right	Print legal name or	as it annoars o	n incurance	card	- 110	ase mane	cricers payable		- tunge in	u 311013, El		
Birthdate MM DD YYY Age Male Home Phone Cell Phone	_	лэ н арреат э Ог	i i ii sui ai ice		Eirct Nas	ma			Middle	Initial		
Home Address: Street City State Zip Sections A and B are to be completed ONLY if we are billing your insurance. Co-payment may apply. We do not accept Kalser. A) Insurance Information: Actina Cofinity* Meritain* Member ID:		DD '	YYYY .							ııııdl		
Sections A and B are to be completed ONLY if we are billing your insurance. Co-payment may apply. We do not accept Kaiser. A) Insurance Information: Aetna	Birthdate		Α <u>ς</u>	16.								
A) Insurance Information: Aetna Cofinity* Meritain* Member ID: Group # Group # Group # HealthPartners Member ID: Group # Member ID: Group # Medicare Part B Primary Plan Member ID: Group # Medicare Part B Primary Plan Member ID: Group # Medicare Advantage Plan: Member ID: Group # Member ID: Payer ID Rocky Mountain Health Plans Member ID: Group # Rocky Mountain Health Plans Member ID: Group # **Cofinity or *Meritain provide Insurance Phone # Claims Address B) Patient Relationship to Primary Insured: Self Spouse** Child** Other** **Spouse, Child or Other provide Insurance Phone # Member ID DOB Member ID 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? Yes No 4. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No Explain any adverse or allergic reactions: **The current applicable CDE. Influence Information on the consent form for whom I am authorized to make this request. I have read or have had outsidend to me the information. I have had a chance to ask questions outside influence or any other resipilatory diseases on side for any adverse or allergic reactions: **The current applicable CDE. Influence Information on the consent form is the only information false influence in one or to the person named on the improvement of the manufacture. I have been contact influence are any other resipilatory diseases on side of the vaccine and plans the section by a given to me or to the person named on the form for whom I am authorized to make this request. I have read or have had outside the member and the side t	Home Address:	: Street				City	<i>'</i>	State		Zip		
Aetna Cofinity* Meritain* Member ID: Group #	Sections A and B	are to be co	mpleted	ONLY if we	are billin	g your in	surance. Co-pay	ment may	apply. We	do not acc	ept Kais	ser.
Cigna (Cornect Not Accepted) Member ID: Group #	A) Insurance Infor	mation:										
HealthPartners Member ID: Group # Humana (HMOx Not Accepted) Member ID: Group # Humana (HMOx Not Accepted) Member ID: Group # Hedicare Part B Primary Plan Member ID: Group # Hedicare Advantage Plan: Member ID: Group # Payer ID	□ Aetna □Cofinity* □Meritain*				oer ID:				Group #			
Humana (MOX Not Accepted) Member ID: Group # Medicare Part B Primary Plan Member ID: Rocky Mountain Health Plans *Cofinity or *Meritain provide Insurance Phone # Claims Address B) Patient Relationship to Primary Insured: Self □ Spouse** □ Child** □ Other** **Spouse, Child or Other provide Insured's Name: Member ID Obb □ □ DOB □ □ M □ F Answer the following questions, sign and date below: 1. Have you ever had a flu immunization before? 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No 6. Have you ever had a bad reaction to any other vaccine? *The current applicable OD: Influenza Vaccine Influenza Insurance 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 maned on this form for whon I am authorized by make this request. I agree that Front Range I Shots, LIC F-SS Shift have no responsibility of the finance in the person maned on this form for whon I am authorized to make the fire request. I agree that Front Range I Shots, LIC F-SS Shift have no responsibility of the finance removes and the person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release wo	☐ Cigna (Connect Not Accepted) Member								Group #			
Medicare Part B Primary Plan Member ID: Group #	☐ HealthPartners				oer ID:				Group #			
Medicare Advantage Plan:	☐ Humana (HMOx Not Accepted)				Member ID: Group #							
Rocky Mountain Health Plans	☐ Medicare Part	Meml	oer ID:				Group #					
*Cofinity or *Meritain provide Insurance Phone # Claims Address B) Patient Relationship to Primary Insured: Self Spouse** Child** Other** **Spouse, Child or Other provide Insured's Name: Member ID DOB M F Answer the following questions, sign and date below: 1. Have you ever had a flu immunization before? Yes No 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? Yes No 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No 6. Have you ever had a bad reaction to any other vaccine? *The current applicable CDC Influenza Vaccine Information Statement has been provided to me. I have read or have had explained to me the information. I have had a chance to the peson named on this form for whom I am authorized person named on this form for whom I am authorized person named on this form for whom I am authorized person in the consent primary adverse or allergic reaction on the consent from is the only information from the tone from the one or suffer any adverse reaction following administration of the influenza vaccine. * Notice of Privacy Practices: The information on the consent from is the only information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to you or an authorized person win amil, email, or fax. Any other release would require your authorization. Vou copy of Motice of RRSS Privacy Practices * I understand that I am responsible Person: Note the privacy Practices of the provided in the provided influenza vaccine emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to	☐ Medicare Advantage Plan: Member ID:						Payer ID					
B) Patient Relationship to Primary Insured: Self Spouse** Child** Other** **Spouse, Child or Other provide Insured's Name:	☐ Rocky Mountain Health Plans Member ID:								Group #	-		
Answer the following questions, sign and date below: 1. Have you ever had a flu immunization before? 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? 6. Have you ever had a bad reaction to any other vaccine? 7. Explain any adverse or allergic reactions: 8. The current applicable CDC Influenza Vaccine Information Statement has been provided to me. I have read or have had explained to me the information. 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 on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRS) shall have no responsibility or liability if I or the named person contract influenza vaccine. 8. Notice of Privacy Practices: The information on the consent form is the only information FRS has about you. Information may be used and disclosed for insurance reimbursement purposes and pregner yet returned review of evelops as a result of this immunication. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of Notice of FRS's Privacy Practices * I understand that I am responsible for payment to FRS's if vaccination is not fully covered by insurance company and there is a \$25 fee for returned checks. 8. Signature of Responsible Person: Insurance Coding and Billing Information for Influenza Vaccination Pluzone High Amount Paid Left Deltoid RN Date Date Date Date Date Date Date Date Date D	*Cofinity or *Meritain provide Insurance Phone # Claims Address											
Answer the following questions, sign and date below: 1. Have you ever had a flu immunization before? 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? 6. Have you ever had a bad reaction to any other vaccine? 7. Explain any adverse or allergic reactions: 8. The current applicable CDC Influenza Vaccine Information Statement has been provided to me. I have read or have had explained to me the information. 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 on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRS) shall have no responsibility or liability if I or the named person contract influenza vaccine. 8. Notice of Privacy Practices: The information on the consent form is the only information FRS has about you. Information may be used and disclosed for insurance reimbursement purposes and pregner yet returned review of evelops as a result of this immunication. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of Notice of FRS's Privacy Practices * I understand that I am responsible for payment to FRS's if vaccination is not fully covered by insurance company and there is a \$25 fee for returned checks. 8. Signature of Responsible Person: Insurance Coding and Billing Information for Influenza Vaccination Pluzone High Amount Paid Left Deltoid RN Date Date Date Date Date Date Date Date Date D	B) Patient Relatio	nship to Prim	ary Insure	d: □ Self □	Spouse**	^k □ Child	** □ Other**					
Answer the following questions, sign and date below: 1. Have you ever had a flu immunization before? 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? 6. Have you ever had a bad reaction to any other vaccine? 7. Explain any adverse or allergic reactions: 8. The current applicable CDC Influenza Vaccine Information Statement has been provided to me. I have read or have had explained to me the information. 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 on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRFS) 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 influenza vaccine. 8. Notice of Privacy Practices: The information on the consent form is the only information FRFS has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this inmigration. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of Notice of PRRS's Privacy Practices 8 I understand that I am responsible for payment to FRFS if vaccination on the formation of the payment of PRFS in Practices are all the provided to the payment of PRFS in Practices and the provided to the payment of PRFS in Practices and the provided	=	-	-		-				Г	OOB		⊓М⊓Е
Insurance Coding and Billing Information for Influenza Vaccination	 3. Have you of 4. Do you cut 5. Do you hat 6. Have you of Explain any act * The current applicabet to ask questions and to the person named the named person of * Notice of Privacy of the privacy of the purpose of	ever had an rrently have ve a history ever had a ladverse or allowed by the control on this form for on this form for practices: The incoses and to provided person via more rently have been and to provide the provided person via more rently have been and to provide the provided person via more rently have been and to provide the provided person via more rently have been and to provide the provided person via more rently have been and to provide the provided person via more rently have been and to provide the provided person via more rently have a history provided person via more rently person via more rently person via more rently person via more	adverse of Guillai oad reacti ergic reacti ergic reacti whom I am a on on my other information on ide emergenciail, email, or f	or allergic report moderate or moderate on-Barre Synon to any or tions:	eaction to e or severe drome (a ther vacci ant has been p a. I believe I u ke this reques se or suffer a m is the only i emergency d lease would re	any come acute ill severe pne? rovided to minderstand that. I agree thany adverse rieformation Flevelops as a equire your a	ponent of the vilness with or will aralytic disease, e. I have read or have the benefits and risks of at Front Range Flu Shote eaction following admit RFS has about you. In result of this immunization. You can in the second s	had explained the vaccine a ts, LLC (FRFs formation of a trick) and the vaccine and the vaccin	er? ed GBS)? d to me the ir ind I ask that i) shall have r he influenza v y be used and iquest, a rece quest a copy	information. I hat the vaccine be to responsibility vaccine. If disclosed for the total value of the total v	Yes Yes Yes Yes Yes ave had a given to o or or liabilities	No No No No chance me or y if I or
Ont Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120 None 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363 Iuenza												
Injection site (0.50mL) Injection site (VIS Provided:				5
pe Shot FluceIvax Shot Dose Shot Control of the Private Location: 60 60 60 60 60 60 60 6	none 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363						• • • • • • • • • • • • • • • • • • • •					
agnosis Code: ICD-10 Z23 Z23 Z23 accine Admin. Code: 90471 90471 G0008 \$ accine Code: 90686 (S) 90674 (S) 90662 \$	rpe ervice Location:	Shot	Flucelvax	Shot Dose Sh	-	, . ,		-		Date		
accine Code:	agnosis Code: ICD-10	Z23	Z23	Z23	\$:g 2 00.0					
= 90000 (NI) = 90700 (NI) = Exp. Date	accine Code:	□ 90686 (S)	□ 90674	(S) 90662	\$ \$							
		□ 90008 (M)	⊒ 90756	(141)	Φ			Exp. Date				

Aetna CIGNA Cofinity DCSD HP Humana MC MEDADV Meritain RMHC Comp CreditCard Check#__

Card Type

Name

CC Email: