



CONSENT FOR TREATMENT INFLUENZA Immunization

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

Please print. Use legal name or name as it appears on insurance card of person getting vaccinated.

<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Last Name	First Name	Middle Initial	Birthdate (MM - DD - YYYY)	Age	Gender
<input style="width:95%;" type="text"/>					<input style="width:95%;" type="text"/>
Home Address		Apt #	City	State	Zip
Phone#: <input type="checkbox"/> Home or <input type="checkbox"/> Cell					

This section is to be completed only if we are billing your insurance.

Co-payment may apply. We do NOT ACCEPT Kaiser. Exclusive provider organizations (EPOs), types of private individual and family health insurance plans, are NOT ACCEPTED including, but not limited to, Cigna Connect, Cigna Freedom, and Humana HMOX. UnitedHealthcare CORE, Charter, Navigate, Centura, Colorado Doctors Plan or any short-term policies are NOT ACCEPTED.

- Aetna Cofinity Meritain: Cofinity & Meritain Insurance Ph # _____ Claims Address _____
- Cigna
- HealthPartners
- Humana
- Medicare Part B is my Primary Insurance Plan or Railroad Medicare is my Primary Insurance Plan
- Medicare Advantage Plan: _____
- Rocky Mountain Health Plans
- UMR Insurance Phone # _____ Claims Address _____
- UnitedHealthcare

Insurance Member ID#

Group Plan or Payer ID
 Self Spouse* Child* Other*
Patient Relationship to Primary Insured

***Spouse, Child or Other provide Primary Insured's Name**

*** Primary's Member ID**
 / / Male Female Other
***Primary's Birthdate (MM/DD/YYYY) and Gender**

Answer the following questions, sign and date below:

1. Do you currently have a fever, chills, or moderate or severe acute illness with or without fever? Temp: _____ Yes No
2. Do you have a cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? Yes No
3. Have you ever had a flu immunization before? Yes No
4. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No
5. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? 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? Yes No

Explain any adverse or allergic reactions: _____

- ★ 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.
- ★ **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 immunization. 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 FRFS's Privacy Practices*.
- ★ I understand that I am responsible for payment to FRFS if vaccination is not fully covered by insurance company and there is a \$30 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding and Billing Information for Influenza Vaccination							
Front Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120 Phone 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363						VIS Provided: Inactivated Influenza Vaccine 08/15/2019	
Influenza Type	Quadrivalent Shot	Quadrivalent Flucelvax Shot	Fluzone High Dose Shot	Seqirus Flud Shot	Amount Paid	Injection site (0.50mL)	RN _____ Date _____
Service Location:	60	60	60	60		<input type="checkbox"/> L Deltoid	Mfg
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23		<input type="checkbox"/> R Deltoid	Lot #
Vaccine Admin. Code:	90471	90471	G0008	G0008			Exp. Date
Vaccine Code:	<input type="checkbox"/> 90686 (S) <input type="checkbox"/> 90688 (M)	<input type="checkbox"/> 90674 (S) <input type="checkbox"/> 90756 (M)	90662	90653	\$ _____		

Clinic Location: _____ Invoice _____

Aetna CIGNA Cofinity DCSD Health Partners Humana MC MEDADV Meritain RMHC Comp Cash _____ Check # _____
 Credit Card Charged at Clinic Yes No Email: _____ Name _____ No# _____ Exp. Date _____ Security Code _____ Zip Code _____ 06.17.2020