Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

CONSENT FOR TREATMENT INFLUENZA Immunization

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

Please print. Use name and gender as it appears on insurance card of person getting vaccinated.

Last Name	First Name	Middle Initial	Birthdate (MM - DD - YYYY)	Age	❑ Male ❑Female ❑Other Gender
			/ /		

Home Address

Phone#: ❑ Home or ❑ Cell

Insurance Billing. Answer questions and provide all insurance Member ID#'s Co Pays may apply.

You are responsible for payment if vaccination is not covered by insurance. Benefits are subject to all contract limitations and the member's eligibility status. INSURANCES NOT ACCEPTED include but are not limited to: Kaiser, Medicaid, Cigna True Choice Medicare PPO, Freedom, Humana HMOX, UHC Centura, DU Plans.

❑ Aetna □ First Health □ Meritain

❑ Cigna ❑ HealthPartners ❑ Humana ❑ UMR ❑ UnitedHealthcare Plan Name:_____

❑ Anthem BCBS Deductible, copayment, & co-insurance may apply to any plan. Verification of benefits or coverage is not a guarantee of eligibility or payment. Actual payment is based on the terms & conditions of the plan. All claims are subject to review upon submission.

Insurance Member ID # | Group # | Payer ID # | Insurance Plan Name | ❑ Self ❑ Spouse* ❑ Child* ❑ Other* Patient Relationship to Primary Insured

Provider Services Phone # listed on back of Id card | Insurance Medical Claims Address listed on back of Id card

*If you are a Spouse, Child or Other provide Primary Insured's Name | *Primary Insured's Member ID | *Primary Insured's Birthdate (MM/DD/YYYY) □Male □Female □Other Gender

❑ Medicare Advantage Plan _____ □HMO □ PPO Member ID _____

Provider Services / Customer Service Phone Number listed on back of card _____

❑ Medicare Part B # _____ ❑ Railroad Medicare # _____

Answer the following questions, sign, and date below:

1. Have you ever had a flu immunization before? Yes No
2. Do you currently have a fever, chills, or moderate or severe acute illness with or without fever? Yes No
3. 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
4. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? 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? Yes No

Explain any adverse or allergic reactions: _____ T _____

★ 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*.

★ **CIIS Notification Information:** You/your child's vaccine information may be reported to the Colorado Immunization Information System (CIIS), a confidential, secure, statewide immunization registry. You may choose to exclude you/your child's information from CIIS at any time. Contact FRFS for further information.

★ 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 • NPI 1598801615

Influenza Type	Quadrivalent Shot	Quadrivalent Flucelvax Shot	Fluzone High Dose Shot	Seqirus Fluad Shot	Amount Paid
Service Location:	60	60	60	60	
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23	
Vaccine Admin. Code:	90471	90471	G0008	G0008	
Vaccine Code:	❑ 90686 (S) ❑ 90688 (M)	❑ 90674 (S) ❑90756 (M)	90662	90694	$_____

Injection site 0.5mL

☐ L Deltoid

☐ R Deltoid

Fluzone High-Dose 0.7mL

VIS Provided: Inactivated Influenza Vaccine 08/06/2021

RN _____ Date _____

Mfg

Lot #

Exp. Date

Clinic Location: _____ 8.14.23 Invoice_____

❑Credit Card #_____ Charged at Clinic ☐ Yes ☐ No Email: Name No# Exp. Date Security Code Zip ❑Comp ❑Cash ❑Check #_____