Influenza Immunization Consent Form 2018-2019

PLEASE PRINT CLEARLY – *form must be completed to receive a flu shot*

Do you have Medicare/Medicare Advantage? ☐ Y ☐ N

EMPLOYER NAME:_____

☐ **BILL INSURANCE** *(FILL OUT INSURANCE INFO BELOW)* ☐ **BILL EMPLOYER** ☐ **MEDICARE WAIVER SIGNED**

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____

Gender: ☐ M ☐ F ☐ Other	**DOB:** ☐ √ **if under 18**	**Ph#:** ( )
Address (Street, City, State, Zip):		

Have you ever had:		**Nurse Comments**
Life threatening reaction to a flu shot	☐ Y ☐ N	
Guillain-Barre Syndrome	☐ Y ☐ N	
Severe allergy to eggs	☐ Y ☐ N	
Are you currently ill with a fever?	☐ Y ☐ N	

Insurance Information: Responsible Party if payment denied by Insurance: ☐ **Employee** ☐ **Employer**

☐ **MODA** ☐ **Regence Blue Cross** ☐ **Pacific Source** ☐ **Providence**

Insured Name: ☐ **Self** _____ **Relationship:**_____

ID#:_____ **GROUP#:**_____ **Insured DOB:**_____

I have read/had explained to me the information about influenza and influenza vaccine (VIS 08/07/15). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither Cascade Health nor their sponsor shall have any responsibility or liability if I contract influenza, or other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. By signing below, I consent to the release of this consent form to my employer/insurance company for billing purposes; unless I am paying for the vaccination myself then no release is necessary.

Signature:_____ **Date:**_____

CLINIC USE ONLY					
Fed Tax ID	93-0421470		**Clinic Location:** Cascade Health		
NPI#	1477714467	**MFG:**	**GSK**	**Sanofi**	
CPT (Vaccine)	90686	**LOT#:**	☐ 4ZY53 exp.06/30/19	☐ UT6261KA exp. 06/30/19	☐
CPT (Admin)	90471	**LOT#:**	☐ JZ3B7 exp.06/30/19	☐	☐
Dx Code	Z23	**LOT#:**	☐ LB549 exp.06/30/19	☐	☐
Charge	$32.00		**Injection Site:** ☒ IM ☐ R Upper Deltoid ☐ L Upper Deltoid		

☐ Abundez, Jessica MOA ☐ Hatton, JoAnn RN ☐ Cline, Curtis MOA ☐ deBroekert, Martha RN
☐ Feldman, Cindi RN ☐ Galbraith-Bain, Deanne MOA ☐ Johnson-Gibson, Lindsey ☐ Lopez, Roxye MOA
☐ Marks, Carla RN ☐ Mueller, Jan RN ☐ Royer, Adrienne RN ☐ Rowe, Laurie RN
☐ Sanborn, Wendy RN ☐ Swan, Whitney MOA ☐ Kehl, Jennifer, RN ☐ Other: Mary Joy Sahara, RN