Flu Consent 2021-2022 Adult – Non-Medicare (19 years & older)

Dickinson-Iron District Health Department □Checked by Clerk

Patient's Name: _____ **DOB:** _____
Last **First** **Middle**

AGE: _____

	Circle answers
Are you sick today?	YES NO
Are you allergic to eggs?	YES NO
Have you had a serious reaction to a previous dose of influenza vaccine?	YES NO
Do you have any other serious allergies? Please list:	YES NO
Have you ever had Guillain-Barre' Syndrome? (type of temporary severe muscle weakness)	YES NO

"I have read or have had explained to me information about the influenza vaccine as in the attached vaccine information sheet. I have completed the questions on the back side of this consent. I have had a chance to ask questions that 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 for whom I am authorized to make this request."

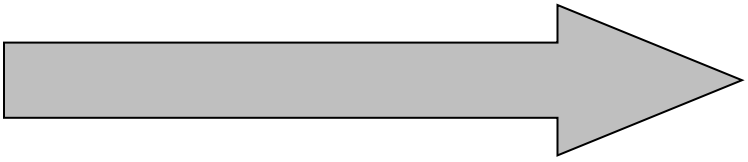
"I authorize the Dickinson-Iron District Health Department, DIDHD, to release all necessary information and records for the billing and receiving payment for services received. I authorize and assign directly to the DIDHD any and all benefits I may be entitled to and are otherwise payable to me for these services. After payment is received from my insurance company, I understand I may be responsible for any balance on my account for which I will receive a statement. If however, I personally receive payment from my insurance company for these services, I will forward this payment to the DIDHD."

Michigan Medicaid rules state that "When a Medicaid beneficiary is eligible for, but not enrolled in Medicare Part B, the Michigan Department of Community Health will reject payment for these Medicare Part B services. If Michigan Medicaid should deny payment for the influenza immunization because I am eligible for Medicare Part B, but not enrolled, *I will be responsible for payment for this service.*

"I acknowledge that I have received a copy of the DIDHD's Notice of Privacy Practices."

_____ _____
Patient's Signature **Date Shot Received**

Please complete back side of form



Patient Name: _____ Last First MI			Date of Birth:
Mailing Address:			□ Male □ Female
City:	St:	Zip:	Phone:

Only complete this section if the service is being billed to private health insurance

Name of Insurance Company:		
Group Number:		
Insurance Billing Address:		Ins. Phone #:
Contract/Policy/ID #:		
Subscribers Information (Policy Holder of Insurance)		
Subscriber's Employer**:**		
Subscriber's Relationship to Patient:		
□ Self - **If Self, stop here**		
□ Spouse □ Child □ Other **(Provide subscriber information below)**		
Last Name:	First:	Middle Initial:
Date of Birth:		
Sex: □ Male □ Female		
Is subscriber's address same as patient's? □ Yes □ No, if no complete address below.		
Address (Street):	City:	State: Zip:
Phone:		

OFFICE USE ONLY

Use Private/Insurance Vaccine for everyone

□ Bill Medicaid ID # _____ Health Plan (circle plan): UPHP FFS

□ Bill Business or Agency: _____ Prior arrangements must be made

□ Bill Health Insurance

□ Self Pay: (Circle payment)
$35 - *Flu (injectable)* *$70 – High Dose Flu (≥ 65 years of age)*

Cash____ *Check #_____* *Cashier's Initials:_____*

□ Check here if administration is documented in ECW

If nurse did not enter this information into ECW, document below

Vaccine Information: Manufacturer: _____ Exp. Date: _____ Lot #: _____

Administration Site: **Injectable** L-Arm R-Arm

Signature/Title of Administrator: _____ RN or LPN **Date Administered**: _____