Flu Consent 2023-2024	Adult – Non-Medicare	(19 years & older)		
Dickinson-Iron District Health	□Cl	□Checked by Clerk		
atient's Name: Last	First	Middle	_ DOB:	
Last	11130	Mildule	AGE:	
			Circle a	nswers
re you sick today?			YE	S NO
re you allergic to eggs?			YE	S NO
ave you had a serious reaction to a	previous dose of influenza vac	cine?	YE	S NO
o you have any other serious allergi	es? Please list:		YE	S NO
ave you ever had Guillain-Barre' Sy	ndrome? (type of temporary se	evere muscle weakness)	YE	S NO
authorize the Dickinson-Iron District Heaceiving payment for services received. Therwise payable to me for these services or any balance on my account for which lompany for these services, I will forward dichigan Medicaid rules state that "When epartment of Community Health will rejet or the influenza immunization because I a ervice. acknowledge that I have received a cop	I authorize and assign directly to tes. After payment is received from will receive a statement. If however this payment to the DIDHD." a Medicaid beneficiary is eligible test payment for these Medicare Part B, but am eligible for Medicare Part B, but and payment for these Medicare Part B, but a state of the state	he DIDHD any and all bene my insurance company, I u ver, I personally receive pay for, but not enrolled in Media art B services. If Michigan M at not enrolled, I will be resp	fits I may be entitled inderstand I may be ment from my insur care Part B, the Mic ledicaid should deni	d to and are responsible rance chigan y payment
atient's Signature	Places complete back		not Received	
	Please complete back	side of form		

Flu Consent 2023-2024

Patient Name: Last First M		Date of Birth	Date of Birth:		
Mailing Address:	1 1100		□ Male	□ Female	
City:	St:	Zip:	Phone:		
			T Hone.		
Only complete this section if	the service is	being billed	to private health i	nsurance	
Name of Insurance Company:					
Group Number:					
Insurance Billing Address:			Ins. Phone	#:	
Contract/Policy/ID #:					
Subscribers Information (Policy	Holder of Insur	ance)			
Subscriber's Employer:					
Subscriber's Relationship to Patien	t:				
□ Self - If Self, stop here					
□ Spouse □ Child □ Othe	r (Provid	de subscriber	information below)		
Last Name:	First:		Middle In	itial:	
Date of Birth:					
Sex: □ Male □ Female					
Is subscriber's address same	as patient's?	□ Yes □	No, if no complet	te address be	
Address (Street):		City:	State	: Zip:	
Phone:					
	OFFICE	USE ONLY			
se Private/Insurance Vaccine fo		OOL OILL			
Bill Medicaid ID #			n (circle plan): UF	PHP FFS	
		Prior arrangements must be made			
Bill Health Insurance					
Self Pay: (Circle payment) \$40 - Flu (injectable) \$80 - ash Check # C	•				
			ocumented in EC CW, document belo		
/accine Information: Manufacturer:	Exp. [Date:	Lot #:		
Administration Site: Injectable L-A	\rm R-Arm				