Medicare Part B Enrolled FLU CONSENT 2023-2024

□ Checked by Clerk

Please print your name EXACTLY as on your Medicare Card, even if incorrect.

Age: _____

_____Date of Birth: _____

Last Name **First** **Middle**

_____

Mailing Address City State Zip

Phone Number: _____ □ **Male** □**Female**

Check what type of Medicare coverage you are enrolled on:

□ **Regular Medicare (Red, White and Blue Card) - Number:** _____ **(include any letters on your card)**

□ **Railroad Medicare - Number:** _____ **(include any letters on your card)**

□ **Medicare Managed Care Plan** (i.e, Humana, Secure Horizon, Medicare Plus Blue)

Managed Care Plan Name:_____

Managed Care Plan ID# _____

Ins Billing Address on back of card (N/A BCBS):_____

Ins Phone#_____

►***Supplemental insurance policies are not billable for this service***

►***If you have an HMO Medicare, the Health Department can not bill for this service.***

	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
*If you take warfarin (a blood thinner) or theophylline (for asthma), the flu shot may cause increased side effects from your medication. * Having a HIV test within 6 months after receiving a flu shot may cause a false-positive result.	

"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 bottom 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 request that the Dickinson-Iron District Health Department, DIDHD, bill Medicare for this service. I authorize the 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."

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

_____ _____

Patient's Signature **Date Shot Received**

OFFICE USE ONLY

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

Site: L - Arm R - Arm

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