

Date: \_\_\_\_\_  
Nurse/MA \_\_\_\_\_ Lt / Rt \_\_\_\_\_  
Vaccine Name \_\_\_\_\_  
Manufacturer \_\_\_\_\_  
Lot # \_\_\_\_\_ Exp \_\_\_\_\_



### Flu Vaccination Consent and Release

Name (Print) \_\_\_\_\_ Sex: Male or Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Circle one: Flu Mist Vaccine

**Information Required to bill insurance (\*\*If Applicable\*\*)**

Name of Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Assignment of Insurance Benefits –**

I understand that all insurance information that I provide is current and accurate. I understand that my insurance information will be submitted to my health plan for payment. I hereby authorize direct payment of medical benefits to The Urgency Room for services rendered. I am aware that due to The Urgency Room's specific contract with Aetna that if I have Aetna they will be billed \$124.00 for the influenza vaccination and this may be applied towards my deductible. I am aware that per The Urgency Room's specific contract with Cigna that if I have Cigna they will be billed for \$145.00 for the influenza vaccination and this may be applied towards my deductible. I understand that if my specific health plan denies my insurance claim for the influenza vaccination; that I am responsible for the full payment. I understand that I may also be responsible for payment of any charges incurred including co-payments and deductibles. I understand that if my insurance is out of network with The Urgency Room that I may receive reduced benefits from my insurance company than if I were to go to an in network provider. By signing below I authorize these terms and conditions.

Signature \_\_\_\_\_

**Questions:**

**Circle one Answer**

- |  |        |
|--|--------|
| 1. Are you allergic to eggs or egg products?                         | Yes No |
| 2. Are you allergic to thimerosal (a preservative in some vaccines)? | Yes No |
| 3. Have you ever had an allergic reaction to a vaccine?              | Yes No |
| 4. Is there a chance you are currently pregnant?                     | Yes No |
| 5. Are you currently sick (not including minor illnesses)?           | Yes No |
| 6. Have you ever had Guillain-Barre Syndrome?                        | Yes No |
| 7. Are you allergic to latex?  | Yes No |
| 8. Is this your first Flu Shot?                                      | Yes No |
| 9. Are you at least 18 years of age?                                 | Yes No |

**Consent**

I have received and read the information sheets for the flu vaccination and I have had an opportunity to ask questions. I do wish to receive the flu vaccine available to me today. I have had an opportunity to read and consider privacy practices notice of The Urgency Room prior to consent. I understand and accept that the vaccination services might be rendered in a non-private setting. I hereby consent to the administration of the flu vaccine. Furthermore, I hereby release and forever discharge for myself, my heirs, executors administrators and assignees, The Urgency Room and their employees, owners and representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one. Children younger than 9 years of age getting influenza vaccine for the first time- or who received influenza vaccine for the first time last season but only one dose – should get 2 doses, at least 4 weeks apart, to be protected.

Signature \_\_\_\_\_ Date \_\_\_\_\_