

Flu Vaccine Consent - Staff

Legal <u>Last</u> Name:		Legal <u>First</u> name:	Age:	Sex: M F	Date of Birth: - -	
School:		Home/Cell Phone:				
Address:		City:	St:	Zip:		
1.	Have you ever had a severe, life-threatening allergic reaction to a previous flu vaccine? Allergic reaction: hives, rash that covers body, difficulty breathing, etc.			<input type="checkbox"/> This is the first time I have ever received a flu vaccine		Yes No
2.	Do you have a severe, life-threatening allergy to eggs?				Yes No	
3.	Have you ever had Guillain-Barre syndrome? (A rare nerve disorder that can cause paralysis)				Yes No	
4.	<p>Please make a copy of both sides of insurance card and attach to this consent. If that is not possible complete boxes below.</p> <p>Subscriber's Legal Name: _____ Subscriber's (person who carries the insurance) _____ Date of Birth: _____</p> <p>Insurance Name: _____ Policy #: _____ Group #: _____</p> <p>Subscriber's address: _____ City: _____ St: _____ Zip: _____ (if different from person receiving vaccine)</p>					
<p>Consent to Vaccinate: I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for each vaccine I will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each vaccine. Consent to Treat: I hereby request and authorize MMH-employed physicians and their staff to administer immunization(s) to me. I authorize staff to perform various serum tests on a sample of my blood in the event that a health care worker has accidentally been exposed to my blood or bodily fluids. Release of Information: I authorize MMH staff to release information that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. Assignment of Benefits: I hereby authorize payment directly to MMH in return for rendering the services described herein. Privacy Practices: I understand that the MMH Joint Notice of Privacy Practices provides information about how MMH may use and disclose protected health information. By signing this form I acknowledge that I have either: (a) received and reviewed a copy of the Notice via hard copy or email; or (b) have been offered an opportunity to receive the Notice but do not wish to do so. A copy of the Notice can be requested at any time by contacting (812) 933-5291. Financial Responsibility: I acknowledge and agree that: (i) I am legally responsible for this account and all costs associated with the collection of this account; (ii) account balances after insurance must be paid in full within thirty (30) days of patient billing, unless other payment arrangements have been made, to avoid collection placement; (iii) any costs or expenses we incur to collect payment from you, including collection fees, attorney fees or other fees will be added to any outstanding balance; and (iv) there will be a \$25.00 service charge on all returned checks. Release: I knowingly and voluntarily assume all risk in connection with my receipt of an immunization. I hereby release MMH, its directors, officers, physicians, employees and agents from any and all liability or claim for damages arising from or related to such immunization. I further acknowledge that no guarantees have been made to me as to the results of an immunization and that it is solely my responsibility to follow up with a physician for any medical diagnosis, examinations, advice or treatment.</p>						
5.	_____			_____		
	Signature			Date		

Office Use Only: CPT Code: Influenza Quad PF 90686
 Funding source: Insurance
 Manufacturer: GSK
 Lot #: 4799F
 Exp date: 6-18-18
 VIS dated: 8-7-15

Date administered:
 Administered IM by:
 Site: Deltoid: Left Right