Hartford HealthCare at Home

2020 Influenza Immunization Consent Form

Please Print Legibly

Name: First ____________________ **Middle Initial** _____ **Last** ____________________________ ☐ **M** ☐ **F**

Address ____ **Phone** __________________________

City ______________________________ **State** _____ **Zip Code** ________ **Date of Birth** __________

Primary Insurance Company:

Insurance ID# ______________________________

Do not write in names – only use checkbox options below

☐ Medicare ☐ Aetna Medicare ☐ Anthem/BCBS Medicare ☐ ConnectiCare Medicare

☐ Aetna ☐ Anthem/BCBS ☐ ConnectiCare ☐ Cigna

Who carries the health insurance? ☐ Self ☐ Other Person (a parent, spouse, etc.)

Self-Pay: ☐ Flucelvax – $42 ☐ Flublok – $75 **Please Note:** If your insurance is not listed above, Self-Pay rates will apply

Check # __________ Check Date ______________ Check/Cash Amount $ ______________

Bill Company: ☐ ____

(need company approval to use this option)

Please answer the following questions:

Temperature __________

☐ Yes ☐ No **Have you ever had a flu shot?**

☐ Yes ☐ No Are you allergic to eggs or Thimerosal?

☐ Yes ☐ No Have you ever had a serious reaction to a flu shot?

☐ Yes ☐ No Have you ever had Guillain-Barré Syndrome?

☐ Yes ☐ No Are you experiencing fever, muscle aches, loss of sense of smell or taste, congestion, nausea, vomiting or diarrhea or are you taking an antibiotic?

I have read, or have had explained to me, the information sheet about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or Medicare HMO claim, or for other insurance purposes**. I agree that if my insurance company does not pay for the vaccine or if a co-pay or deductible applies, I will be responsible for payment.**

I acknowledge receipt of the Notice of Privacy Practices: I have had the opportunity to ask questions regarding my rights relating to the use and disclosure of my Protected Health Information (PHI).

Signature of Recipient (or Guardian): ________________________________ **Date:** ____________

For Nurse use only

(Please select Vaccine Name and enter Lot Number and Expiration Date)

Injection Site: ☐ Right Arm **Vaccine:** ☐ **Flucelvax** Lot # ____________ Exp. Date __________

☐ Left Arm ☐ **FluBlok** Lot # ____________ Exp. Date __________

Nurse's signature ______________________________________ **Date Admin.** ______________

(Signature of Nurse and date vaccine administered)

Clinic Location/Company Name ____

(Please clearly print name of clinic or company as listed on Flu Schedule)