Hartford HealthCare at Home

2017 Influenza Immunization Consent Form

Name: First _____ **Middle Initial** _____ **Last** _____ ❍ **M** ❍ **F**

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____ **Date of Birth** _____

Insurance Carrier: **Insurance ID#** _____

❍ Medicare ❍ Aetna Medicare ❍ Anthem Medicare ❍ ConnectiCare Medicare

❍ Aetna ❍ Anthem ❍ ConnectiCare ❍ Cigna

Is the Insurance policy in your Name? If NO, please fill out the information below:

Name of person who carries the insurance _____

Their Date of Birth _____ Your Relationship to Them _____

Their Insurance ID # _____

**** Please Note: If your insurance is not listed above, Self Pay rates will apply ****

Self Pay: ❍ Fluarix – $40.00 ❍ Flublok – $50.00

Check # _____ Check Date _____ Check Amount **$** _____

Bill Company: ❍ Company Name: _____

Please answer the following questions:

❍ Yes ❍ No Are you allergic to eggs or Thimerosal?
❍ Yes ❍ No Have you ever had a serious reaction to a flu shot?
❍ Yes ❍ No Are you sick with a fever or are you taking an antibiotic for an infection?
❍ Yes ❍ No Have you ever had Guillain-Barré Syndrome?
❍ Yes ❍ No Have you ever had a flu shot?

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 clinic use only ☐ **HHCAH** ☐ **HCFX**

Vaccine Type: ❍ **Fluarix** ❍ **FluBlok** **Lot #** _____ **Exp Date** _____
(Please enter appropriate vaccine type & lot number)

Injection Site: ❍ **Right Arm** ❍ **Left Arm** **Pediatric Dosage:** _____

Clinic Location: ❍ **Client Home** ***or*** ❍ **Clinic Name** _____
(Please check one location and write name of clinic – needed for billing)

Nurse's signature _____ **Date Admin.** _____
(Signature of Nurse and date vaccine administered – needed for billing)