

Clinic Site:

Last Name	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age
Street Address	City	State	Zip Code	Phone Number	

For Care, Payment and Operations: This allows us to coordinate your care with other healthcare providers and to bill for our services. This also allows your health plan to process your claims and provide services to you. Immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law.

Assignment of Benefits and Responsibility for Payment: This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan. I authorize Homeland Health Specialists, Inc. to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co insurance, collections cost and interest as allowed by law.

Payment Information

Attach a copy of your insurance cards to the consent.

1 st Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
2 nd Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
<input type="checkbox"/> Cash Payment \$	<input type="checkbox"/> Company Payment Company Name:	

SIGNATURE AND ACKNOWLEDGEMENT

I have received, read and understand the current Vaccine Information Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I understand that I may revoke or cancel this consent in writing at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

 Signature of Patient or Legal Guardian

 Date

Staff Verification

Health History

No Yes

- 1. Are you sick today? (Fever of 100.5 or higher on the day of clinic?)
- 2. Have you ever had Guillain-Barre syndrome within 6 weeks of an influenza vaccination?
- 3. Are you allergic to eggs? Do you just get hives? _____
- 4. Do you have a life threatening allergy to an antibiotic or gelatin?
- 5. Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?
- 6. Do you have long term health issues such as: Heart disease, lung disease, asthma, kidney disease, neuromuscular or neurological disease, liver disease, metabolic disease, diabetes, anemia, blood disorders, cancer, leukemia, HIV/AIDS, immune problems, or have taken medications in the past 3 months that weaken the immune system such as prednisone, cortisone, steroids, anticancer drugs or radiation treatment.
- 7. Are you pregnant?
- 8. Are you receiving antiviral medications (like Relenza or Tamiflu)?
- 9. Are you taking aspirin or on long term aspirin containing medication?
- 10. Will you have close contact with a person in protective isolation because of a bone marrow transplant?
- 11. Have you received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?

FOR CLINIC USE ONLY- DO NOT WRITE IN THIS BOX

<p>VACCINE</p> <p>Manufacturer: _____ Trade Name: _____ <input type="checkbox"/> Trivalent <input type="checkbox"/> Quadrivalent Dose: _____ Lot #: _____ Expiration Date: _____ Dx code: Z23</p>	<p>VACCINATOR</p> <p>Date of VIS: <u>08/2015</u> Administered by: _____ Date Administered And VIS provided: _____</p>	<p>ADMINISTRATION</p> <p>Intramuscular Injection Site</p> <p><input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh</p> <p>FluMist Nasal Spray-Ages 2-49 only</p> <p><input type="checkbox"/> Intranasal</p>
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