INFLUENZA (Age 18 Years & Over)

VNA CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive. ● No severe allergic reactions to eggs, egg products, formaldehyde, Thimerosal, vaccine components, or latex. ● Does not have an acute respiratory illness or a fever. ● No history of Guillain-Barre' Syndrome. ●Has not had a reaction to a flu vaccine in the past.

RELEASE OF INFORMATION

I authorize all Visiting Nurse Association (VNA) records to be released and reviewed by any authorized representative of my third party payer or employer as required, to apply for Medicare payment under the Title XVIII of the Social Security Act or other applicable payer plans. I authorize this information to be released and reviewed by any Federal, State, or accrediting body or agency as required by the regulatory, licensing or accrediting body. As applicable, I authorize all VNA records to be released to my employer. As applicable, I request that payment of authorized services be made in my behalf.

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for supplies and vaccine provided by them. **I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I AGREE TO PAY ANY/ALL COLLECTION COSTS INCLUDING ATTORNEY FEES AND COURT COSTS, IF THIS ACCOUNT IS SENT TO AN OUTSIDE LAW FIRM OR AGENCY FOR COLLECTIONS.**

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the current Influenza Vaccine Information Statement prior to my vaccination. I understand all the risks and benefits involved and I have had a chance to ask questions. ● I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. Mild reactions may include soreness, redness and/or swelling at the injection site, or arm stiffness. General reactions may include headache, fatigue, muscle pain, fever, or malaise that can persist for 1-2 days. Severe reactions may include anaphylaxis or death. ● I release VNA, its officers, employees, affiliates, successors or directors from any and all liability that might arise from or in any way connected with this vaccine on behalf of my heirs, my personal representatives, and me.

COMPLETE ALL INFORMATION BELOW TO RECEIVE INFLUENZA VACCINE

First Name ● **MI** ● **Last Name**

Address Number ● **Street Name** ● **Sex M/F**

City ● **State** ● **Zip Code**

Age ● **Date of Birth** – – ● **Area Code** ● **Phone Number** –

Race: ☐ **White** ☐ **African American/Black** ☐ **Asian** ☐ **Hawaiian/Pacific Islander** ☐ **American Indian**

Ethnicity: ☐ **Hispanic/Latino** ☐ **Non-Hispanic/Latino**

_____ **(Initials)** I have read and been offered to receive a copy of the Notice of Privacy Practices prior to services, and I have had the opportunity to have my questions answered.

CONSENT TO RECEIVE VACCINE

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

_____/_____/_____ **X**_____/_____

Date — Signature of Person, Parent or Legal Guardian receiving vaccine — / Relationship to Patient

FOR CLINICAL USE ONLY. DO NOT WRITE BELOW THIS BLACK LINE.

Indicate Payment

Bill **Cash** **Check** **Carpenters** **Essence** **GHP** (All)
Medicare Part B **Mercy** (All) **SSM Exclusive Choice** **Voucher** **Other**

Indicate Billing / Insurance ID

Clinic ID#

X _____/_____/_____
Nurse Signature — Date Given

0.5 mL Lot Given
A B C D E F G H I J K L M

IM Site Given
Deltoid ● Thigh
L ● R