CONSENT FOR VACCINATION

Full Name (last, first, middle initial): ____

Address: ___________________________ **City:** ______________ **Zip:** _______ **Phone #:**________________

Birth Date: ________________________ **Age:** _______ **Male** ___ **Female** ___

Social Security Number: ____________________________

I give permission for HCMH/HCPH to update Iowa's Immunization Registry Information System (IRIS). This will show your doctor that you had a flu shot. **Yes** ________ or **No** ________

Please check one of the following payments:

_____**Medicare ID#** (Write # and **Include Proper Letter**) ______________________________________

_____**Bill my health insurance** **Policy ID#:** ____

Policyholder name: ____________________________ Policyholder birth date: __________________________

Group name and number: ________________________ Insurance Company Name: ______________________

_____ **(initials)** I request that HCMH bill my insurance company for this service, and authorize payment of benefits by my insurance company be made directly to Humboldt County Memorial Hospital.

_____ **Bill Business** _____________________________ **Amount to bill** _______________________________

_____ **Private Pay** **Clinic Location** ______________________________

For Children 6 months Through 18 years: Please fill in this section also.

Has child ever had a flu shot/mist? ___

Please mark one of the following:

_____*6 mo to 18 yrs and on Title 19/Medicaid*

_____*Has no health insurance*

_____*Has health insurance that does not cover immunizations*

_____*Has health insurance that covers immunizations*

_____ *American Indian or Alaska Native heritage*

OFFICE USE ONLY:

_____**Medicare**

_____**Insurance**

_____**Bill Business**

_____**Private Pay**

_____**VFC eligible**

Payment Received:
__ Cash __Check # ______

I have read the vaccine information statements or have had it explained to me. I have had the chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the vaccine and consent to receive it. I accept responsibility for seeking medical attention for any problems with the vaccination. I understand that this vaccine in some people may cause flu-like symptoms and in rare incidents Guillain–Barre Syndrome. **I am consenting to flu vaccine.**

YES NO

___ ___I have had a severe (anaphylactic) reaction to a flu shot/mist.

___ ___I am allergic to eggs, thimerosal-containing products (eye contact lens solution), mercury containing products, gentamicin, or neomycin.

___ ___I am moderately or severely ill at this time.

___ ___I have a history of Guillain-Barre Syndrome (GBS).

___ ___I have an allergy to latex (if yes, tell the nurse before vaccination).

Signature: _____________________________________ Today's Date: _________

FOR NURSES ONLY: Vaccine Administration Record

INFLUENZA VACCINE

IM / Intradermal / Intranasal Site: RD / LD / Intranasal / R thigh / L thigh

Mfg/Lot#_______________________ **Date:** ________ **Administered by:** ________________________

Do they need to return for dose # 2? YES___ NO___ If yes, tell them to schedule 2nd dose appt.

__**Registration Complete** **Hospital Account #**_________________ __**Billing Complete** __**IRIS Entry Complete**

PATIENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service

____ ____________________

Signature of Patient, Authorized Representative or Responsible Party Date