Flu Consent 2022/2023

Patient Name:_____ Date of Birth:_____ Male/Female_____

Address:_____

Phone:_____ Email:_____

Policy Holder:_____ Policy Holder's DOB:_____

Insurance/Medicaid/Medicare ID# & Group#:_____

HIPAA RELEASE/TERMS & CONDITIONS

- I certify that the information I have provided is true and accurate.
- I have received a copy and have had the opportunity to read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the statement be given to me or the person for whom I am authorized to make this request.
- I have been provided the opportunity to read TCHD's Notice of Privacy Practices and have this policy explained to me. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be included in a centralized, statewide database and can be shared with schools, daycare centers, health care providers, and other health care professionals as necessary to verify immunizations status, audits, and public health studies. In addition, I agree that this information may be shared with health care personnel or public health personnel who have a legitimate need to have access to the information in order to assist a patient or to protect the health of others closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying TCHD in writing. I understand that once my data is shared with another individual or agency that it may lose the protections provided by the Privacy Rule, and may be subject to redisclosure by the recipient.
- As a courtesy, we will bill your insurance/Medicaid. You are responsible for contacting your insurance to verify the services are covered. **BY SIGNING BELOW YOU GIVE US PERMISSION TO BILL INSURANCE/MEDICAID AND ACKNOWLEDGE THAT YOU WILL BE RESPONSIBLE ANY BALANCE NOT COVERED BY YOUR INSURANCE.**

TERMS & CONDITIONS

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay collection fees. The undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee. You authorize us to call you at any mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

I authorize and consent to such medical testing and treatment as the health care providers of the TriCounty Health Department may recommend. I understand the benefits and risks of the vaccinations I have received today.

❑ I am 18 years of age or older ❑ I am the parent and/or legal guardian ❑ Other:_____

_____ _____
Printed Name of Patient or Legal Guardian Date:

_____
Signature of Patient or Legal Guardian

I,_____ hereby grant permission for my family and or I to participate and appear in video and or photographs, websites, social media sites for the purpose of promotion of TriCounty Health Department.

FOR OFFICE PERSONNEL ONLY:

VFC	PVT

History of Guillain-Barré Syndrome

Egg Allergy

----------**For Nurse Use Only**----------

Vaccine USIIS/CVX #	Product & Info	Lot # & Expiration	CPT Billing Code	Dose in mls	Injection Site
⬜ **PVT**	**FluLaval:** Ages 6 months and up PFS **Flumist:** Ages 2-49 years	K7752 PH3533 PJ3267	90471 G0008	0.5ml 0.5ml	IM Deltoid or Anterior thigh R / L
⬜ **VFC**	**FluLaval:** Ages 6 months and up PFS **Flumist:** Ages 2-49 years	ZR5K7 JTC77 KH3N5 2G7K9 PH3353	90471 SL	0.5ml 0.5ml	IM Deltoid or Anterior thigh R / L

Nurse Signature_____ Date:_____