

Patient Information (Please Print)

Last Name: _____ First: _____ Gender: M / F / Other

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ Age: _____

Physician: _____

Patient Consent

Special Cautions (See Vaccine Information Sheet for details)

1. If you have any of the following, obtain vaccination under your doctor's supervision
 - * Have had a serious allergic reaction to eggs or a vaccine component, including Thimerosal
 - * Have had previous severe reaction to flu/pneumonia shots
 - * Have an active neurological disorder (delay until stabilized) or history of Guillain-Barre Syndrome
2. If you have an acute infection with fever over 100 F, delay immunization until you are recovered.
3. **High Dose Influenza vaccine is for individuals, aged 65 years and older to help boost immune response.**

I have read the information sheet about the influenza/pneumonia vaccine. The information I have provided above is correct and true to my knowledge. I understand the benefits and risks of the vaccination and request that the vaccine be given to me or to the person listed above, for whom I am authorized to make this request. **If insurance denies payment, or my original method of payment is rejected, I agree to be personally responsible for full payment.**

I understand all information obtained by the VNA will be used only for treatment, payment, or health operations.

I authorize: (please initial)

Signature of person to receive vaccine or authorized to sign

Date

Influenza Regular Injection

Influenza High Dose Injection

Pneumonia Injection

Payment Information (Please show insurance card to receptionist/volunteer)

Medicare B: Medicare # _____ (Must have MBI or Social Security #)

Insurance Company: _____ Phone _____

Claims address _____

Member ID _____ Group # _____

Primary Policy Holder Name _____ Primary Policy Holder Birthdate _____

Patient relationship to policy holder: (circle one) Self Spouse Child Other

Patient Pay Full: Cash \$ _____ Check # _____ Amount \$ _____

Flu: \$38 (\$35 cash/check now) High-dose Flu: \$71 (\$68 cash/check now) Pneumonia: PPSV23 \$145 or PCV13 \$237

Voucher Payment: Voucher # _____ Company: _____

Name: _____ Date: _____ Location: _____

To be completed by VNA Nurse

Flu Vaccine IM: L Deltoid R Deltoid Other _____ **Lot Number** _____

Dose: 0.5 cc Regular 0.5 cc Pres Free

High-dose Flu Vaccine, 0.7 cc, IM: L Deltoid R Deltoid Other _____ **Lot Number** _____

Pneumonia Vaccine, 0.5 cc, IM: L Deltoid R Deltoid Other _____ **Lot Number** _____

*****Nurse Signature** _____