

Patient Information (Please Print)

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

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

Phone: _____ Birthdate: _____ Age: _____

Social Security: _____ Physician: _____
(NA if self/contract pay)

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.

Signature of person to receive vaccine or authorized to sign _____ Date _____
 Please initial I authorize:
 _____ Influenza Regular Injection
 _____ Influenza High Dose Injection (age 65+)
 _____ Pneumonia Injection

Flu: \$38 (\$35 cash/check now) High-dose Flu: \$65 (\$62 cash/check now) Pneumonia: PPSV23 \$140 or PCV13 \$205

Payment Information (Please show insurance card to receptionist)

- Medicare B: Medicare # _____
- MC Replacement: Plan Name _____ Policy # _____ Phone _____
- Primary Insurance Carrier: _____ Claims Address: _____ Phone _____
 Policy # / Member ID _____ Group # / Employer _____
 Policy Holder: _____ Patient relationship to policy holder: Self Spouse Child Other
- Patient Pay Full: Amount \$ _____ cash check # _____
- Voucher Payment: Voucher # _____
- Company Pay Full Company Name _____

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

***Nurse Signature _____