BRING THIS FORM WITH YOU TO THE CLINIC

Visiting Nurse & Hospice of Fairfield County
Trusted care. When you need it most.

22 Danbury Road
Wilton, CONNECTICUT 06897
203-762-8958
www.visitingnurse.net

EIN #061062903 DX CODE: Z23

2020 Seasonal Influenza Immunization Consent Form

NAME – print (as it appears on insurance card)	GENDER ☐ M ☐ F	DATE OF BIRTH ____/____/____	AGE
Email address:			
ADDRESS	CITY, STATE	ZIP	PHONE #

Please bring a copy of your insurance card with you to the clinic.

INSURANCE (primary) – please circle the plan to be billed		INSURANCE ID # (primary)
Medicare Part B Aetna Blue Cross Blue Shield (Anthem or Empire)	ConnectiCare Harvard Pilgrim Health Care	Relationship to Insurance Plan Holder: ☐ Self ☐ Spouse ☐ Child
Name of Plan Holder:		Plan Holder Date of Birth: ____/____/____
INSURANCE (secondary) – please circle the plan to be billed		INSURANCE ID # (secondary)
Medicare Part B Aetna Blue Cross Blue Shield (Anthem or Empire)	ConnectiCare Harvard Pilgrim Health Care	Relationship to Insurance Plan Holder: ☐ Self ☐ Spouse ☐ Child
Name of Plan Holder:		Plan Holder Date of Birth: ____/____/____

SELF-PAY *Insurance claims are to be reimbursed to patient directly.*

Please pay by check payable to Visiting Nurse & Hospice of Fairfield County

Please answer the following questions & discuss any concerns with the nurse.

		Yes	*No*	*Unsure*
1. Have you ever had a severe allergic reaction to influenza vaccine?	1.	☐	☐	☐
2. Do you have a fever of >100°F or feel moderately ill today?	2.	☐	☐	☐
3. Have you ever had Guillain-Barre Syndrome (a severe paralytic illness)?	3.	☐	☐	☐

ACKNOWLEDGMENT AND AUTHORIZATION – I authorize Visiting Nurse & Hospice of Fairfield County (VNHFC) records to be released and reviewed by an authorized representative of my third-party payer or employer as required for payment. I authorize this information to be released and reviewed by any federal or state agency only as required by the regulatory or licensing body of that agency. I agree to release and hold harmless VNHFC, the Town of Wilton and the venue at which the vaccine is being provided, and their respective employees, officers, elected and appointed officials, directors and affiliates from any and all claims, actions, lawsuits and liability that might arise from or is in any way connected with this vaccine. I understand that if I experience any side effects, it is my responsibility to consult my physician at my expense. VNHFC Privacy Policy is available to me on the VNHFC website. I have been provided with the CDC Vaccine Information Statement **(VIS Dated: 8/15/19)** as a part of this registration process. I will have the chance to ask questions before vaccination. I understand the risks and benefits of the influenza vaccine to be given to me or the person I am authorized to make this request. I give VNHFC permission to notify my Primary Care Provider that I have received the vaccine. I understand VNHFC will submit my claim ONLY to insurance providers that VNHFC contracts with for this service and I am responsible to reimburse VNHFC for any charges, co pays and deductibles not covered by my employer, Medicare, or health insurance. If for any reason my claim is denied, I will be billed for the service.

PATIENT SIGNATURE	**DATE:** ____/____/____

For STAFF USE Only

☐ Flublok RIV4 SD 90682 (Protein Science) 0.5mL IM / 18+ years

☐ Fluzone IIV4 SD 90686 (Sanofi) 0.5mL IM ☐ High Dose Fluzone IIV4 SD 90662 (Sanofi) 0.7mL IM / 65+ years

☐ Flucelvax IIV4 SD 90674 (Seqirus) 0.5mL IM ☐ Fluad IIV4 SD 90694 (Seqirus) 0.5 mL IM / 65+ years

ADMINISTERED BY:	DATE ADMINISTERED:

Site:
L Deltoid **L** Thigh
R Deltoid **R** Thigh

LOT # / Exp. Date: