BRING THIS FORM WITH YOU TO THE CLINIC

2021 Covid-19 Immunization Consent Form

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

EIN #061062903 DX CODE: Z23

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 any medication?**	☐	☐	☐

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 will have the chance to ask questions before vaccination. I understand the risks and benefits of the 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 administration service only.

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

For STAFF USE Only

Injection #1

☐ Moderna 1st Admin 0011A

Injection #2

☐ Moderna 2nd Admin 0012A

ADMINISTERED BY:	DATE ADMINISTERED:

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

LOT # / Exp. Date:

DRAFT