INFLUENZA (Age 18 Years & Over)

VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA)

CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive. ● No severe allergic reactions to eggs, egg products, formaldehyde, Thimerosal, vaccine components, or latex. ● Does not have an acute respiratory illness or a fever. ● No history of Guillain-Barrè Syndrome. ●Has not had a reaction to a flu vaccine in the past.

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for service provided by them. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I AGREE TO PAY ANY/ALL COLLECTION COSTS INCLUDING ATTORNEY FEES AND COURT COSTS, IF THIS ACCOUNT IS SENT TO AN OUTSIDE LAW FIRM OR AGENCY FOR COLLECTIONS.

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the current Influenza Vaccine Information Statement (rev.8/7/15) prior to my vaccination. I understand all the risks and benefits involved and I have had a chance to ask questions. ● I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. Mild reactions may include soreness, redness and/or swelling at the injection site, or arm stiffness. General reactions may include headache, fatigue, muscle pain, fever, or malaise that can persist for 1-2 days. Severe reactions may include Guillain-Barrè Syndrome, anaphylaxis or death. ● I hereby release and hold harmless Visiting Nurse Association of Greater St. Louis, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, volunteers and employees, from any and all liabilities or claims whether known or unknown arising out of, or in connection with, or in any way related to the administration of the vaccine(s) listed above.

COMPLETE ALL INFORMATION BELOW TO RECEIVE INFLUENZA VACCINE

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

First Name ● **MI** ● **Last Name**

Address Number ● **Street Name** ● **Sex M/F**

City ● **State** ● **Zip Code**

Age ● **Date of Birth** ● ● ● **Area Code** ● **Phone Number** ●

Email (optional)

Race: □ White □ African American/Black □ Asian Am. □ Hawaiian/Pacific Islander □ American Indian □ Two or More Races

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino

_____ (Initials) I have read and been offered to receive a copy of the Notice of Privacy Practices prior to services, and I have had the opportunity to have my questions answered.

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

□Aetna □ Anthem/Blue Cross Blue Shield □ Cigna □ Coventry □ Essence □ Humana

□ HealthLink □ UHC

□ Medicare Part B (only) □ Medicare Advantage Plan:(please list)_____

Subscribers Name: _____ Subscribers D.O.B. _____/_____/_____ Relationship to subscriber: _____

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

_____/_____/_____**X**_____/_____

Date Signature of Person, Parent or Legal Guardian receiving vaccine / Relationship to Patient

DO NOT WRITE BELOW THIS LINE *For Office Use Only*

Nurse to indicate payment	**INSURANCE MBR ID** _____ ○ **Cash** ○ **Check #** _____ ○ **Bill** ○ **Voucher** ○ **Other** _____		
Clinic ID#	**X** _____ _____/_____/_____ **Nurse Signature** **Date Given**	**0.5 ml Lot Given** **A B C D** **E F G**	**IM Site Given** **Deltoid ● Thigh** **L ● R**