



# CONSENT FOR TREATMENT INFLUENZA Immunization

✓ Please make checks payable to Front Range Flu Shots, LLC or FRFS

Please print. Use legal name or name as it appears on insurance card of person getting vaccinated.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birthdate (MM - DD - YYYY)</b>	<b>Age</b>	<b>Gender</b>
<input type="text"/>					<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<input type="text"/>			<input type="text"/>		
<b>Home Address</b>	<b>Apt #</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Phone#:</b> <input type="checkbox"/> Home or <input type="checkbox"/> Cell

**This section is to be completed only if we are billing your insurance.** You are responsible for payment if vaccination is not covered by insurance.

Kaiser, Medicaid, American Postal Workers Union Health Plan (APWU), and Exclusive Provider Organizations (EPOs), types of private individual and family health insurance plans, including, but not limited to, Cigna Connect, Cigna Freedom, and Humana HMOX are NOT ACCEPTED.  
UnitedHealthcare CORE, Charter, Navigate, Centura, Colorado Doctors Plan, DU Plans or any short-term policies are NOT ACCEPTED.

Medicare Part B is my Primary Insurance Plan *or*  Railroad Medicare is my Primary Insurance Plan  
 Medicare Advantage Plan: \_\_\_\_\_  Anthem Medicare Preferred (PPO) Colorado PERA  
 Aetna  Cofinity  Meritain: Cofinity & Meritain Insurance Ph # \_\_\_\_\_ Claims Address \_\_\_\_\_  
 Anthem BCBS  
 Cigna  
 HealthPartners  
 Humana  
 Rocky Mountain Health Plans  
 UMR Insurance Phone # \_\_\_\_\_ Claims Address \_\_\_\_\_  
 UnitedHealthcare: Plan \_\_\_\_\_

<input type="text"/> <b>Insurance Member ID#</b>	<input type="text"/> <b>Group Plan or Payer ID</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse* <input type="checkbox"/> Child* <input type="checkbox"/> Other* <b>Patient Relationship to Primary Insured</b>
<input type="text"/> <b>*Spouse, Child or Other provide Primary Insured's Name</b>	<input type="text"/> <b>* Primary's Member ID</b>	<input type="text"/> / <input type="text"/> / <input type="text"/> <b>*Primary's Birthdate (MM/DD/YYYY) and Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other

**Answer the following questions, sign and date below:**

- |   |        |
|---|--------|
| 1. Have you ever had a flu immunization before?   | Yes No |
| 2. Do you currently have a fever, chills, or moderate or severe acute illness with or without fever?  | Yes No |
| 3. Do you have a cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? | Yes No |
| 4. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein?  | Yes No |
| 5. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal?   | Yes No |
| 6. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)?  | Yes No |
| 7. Have you ever had a bad reaction to any other vaccine?   | Yes No |

Explain any adverse or allergic reactions \_\_\_\_\_ . T \_\_\_\_\_

- ★ The current applicable CDC *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRFS) shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the influenza vaccine.
- ★ **Notice of Privacy Practices:** The information on the consent form is the only information FRFS has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of *Notice of FRFS's Privacy Practices*.
- ★ **CIIS Notification Information:** You/your child's vaccine information may be reported to the Colorado Immunization Information System (CIIS), a confidential, secure, statewide immunization registry. You may choose to exclude you/your child's information from CIIS at any time. Contact FRFS for further information.
- ★ I understand that I am responsible for payment to FRFS if vaccination is not fully covered by insurance company and there is a \$30 fee for returned checks.

**Signature of Responsible Person:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Insurance Coding and Billing Information for Influenza Vaccination							
Front Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120 Phone 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363 • NPI: 1598801615						VIS Provided: Inactivated Influenza Vaccine 08/06/2021	
<b>Influenza Type</b>	<b>Quadrivalent Shot</b>	<b>Quadrivalent Flucelvax Shot</b>	<b>Fluzone High Dose Shot</b>	<b>Seqirus Fluad Shot</b>	<b>Amount Paid</b>	Injection site (0.50mL)	RN _____ Date _____
Service Location:	60	60	60	60		<input type="checkbox"/> L Deltoid	Mfg
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23		<input type="checkbox"/> R Deltoid	Lot #
Vaccine Admin. Code:	90471	90471	G0008	G0008			Exp. Date
Vaccine Code:	<input type="checkbox"/> 90686 (S) <input type="checkbox"/> 90688 (M)	<input type="checkbox"/> 90674 (S) <input type="checkbox"/> 90756 (M)	90662	90694	\$ _____		

Clinic Location: \_\_\_\_\_ Invoice \_\_\_\_\_

(8.13.21)  Credit Card # \_\_\_\_\_ Charged at Clinic  Yes  No Email: Name No# Exp. Date Security Code Zip  Comp  Cash  Check # \_\_\_\_\_