



CONSENT FOR TREATMENT INFLUENZA Immunization

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

Please Print

Last Name				First Name			Middle Initial	
Birthdate	MM	DD	YYYY	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone	Cell Phone	

Home Address: Street _____ **City** _____ **State** _____ **Zip** _____

This section is to be completed ONLY if we are billing your insurance. Co-payment may apply. We do not accept Kaiser.

Medicare Part B (Primary Plan) Medicare Advantage Plan: _____ Payer ID _____

AETNA CIGNA DCSD Cigna CNIC Cofinity Humana(not HMOx) Rocky Mountain Health Plans

Print Name exactly as it appears on insurance card _____

Member ID # Including any letter(s) _____ Payer/Issuer ID _____ Group ID _____

Insurance Phone # _____ Insurance Claims Address _____

Patient Relationship to Primary Insured: Self Spouse* Child* Other*

*Primary Insured Name: _____ Birthdate _____ Member ID _____ Male Female

*Primary Insured's Address if different than above: _____

Answer the following questions, sign and date below:

- | | | |
|---|-----|----|
| 1. Have you ever had a flu immunization before? | Yes | No |
| 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? | Yes | No |
| 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? | Yes | No |
| 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? | Yes | No |
| 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? | Yes | No |
| 6. Have you ever had a bad reaction to any other vaccine? | Yes | No |

Explain any adverse or allergic reactions: _____

★ The current applicable *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had an opportunity to review FRFS's *Notice of Privacy Practices* and am aware that I can request a copy. I have had a chance to ask questions and, if any, they were answered to my satisfaction. Upon request, a receipt or copy of this form can be sent to me or an authorized person via mail, email, or fax. 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 for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC 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 vaccine.

★ I understand that I am responsible for payment to Front Range Flu Shots, LLC if vaccination is not fully covered by insurance company.

★ I understand there is a \$25 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding and Billing Information for Influenza Vaccination						Do not write below this line.	
Front Range Flu Shots, LLC • P.O. Box 1093, Littleton, CO 80160-1093 • Phone 303-797-3396 Federal Tax ID: 743077363						VIS Provided: Inactivated Influenza Vaccine 08/07/2015 Live Attenuated Influenza Vaccine 08/07/2015	
Influenza Type	Trivalent Shot	Quadrivalent Shot	Fluzone High Dose Shot	FluMist Nasal Spray	Amount Paid	Injection site (0.50mL)	RN _____ Date _____
Service Location:	60	60	60	60		____ Left Deltoid	Mfg _____
Diagnosis Code: ICD-9	V04.81	V04.81	V04.81	V04.81		____ Right Deltoid	Lot # _____
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23		Intra-nasal (0.2mL)	Exp. Date _____
Vaccine Admin. Code:	90471	90471	G0008	90473	\$ _____	____ Nasal Spray	
Vaccine Code:	90658	<input type="checkbox"/> 90686 (S) <input type="checkbox"/> 90688 (M)	90662	90672	\$ _____		
Clinic Location:					\$ _____		

MC MED ADV Aetna CIGNA DCSD CNIC Cofinity Humana RMHC Comp CC Check _____ Cash _____ Invoice _____
 CC Email: _____ Name _____ Card Type _____ No# _____ Exp. Date _____ Security Code _____ Zip Code _____ 08.30.15