Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

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	❑ Male ❑ 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: _____

FluMist Nasal Spray ONLY: Continue & Complete 7 – 12. You must be healthy, 4 - 49 years old, and not pregnant.

7. How old are you? _____ Are you pregnant or nursing? Yes No
8. Have you received any vaccines within the last month or do you plan to receive any within the next month? Yes No
9. Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? Yes No
10. Are you under 18 and on long-term aspirin treatment? Yes No
11. Are you taking Tamiflu® (oseltamivir), Relenza® (zanamivir), amantadine, or rimantadine? Yes No
12. Do you have any of the following illnesses or conditions: Chronic lung disease including asthma, reactive airway disease, one or more episodes of wheezing within the past year, nasal condition serious enough to make breathing difficult, a very stuffy nose, weakened immune system, HIV, currently taking medications that can weaken your immune system, heart disease, kidney or liver disease, diabetes, muscle or nerve disorder that can lead to breathing or swallowing problems, seizure disorder, Cerebral Palsy, anemia, blood disorders, long-term health problems, and / or hypersensitivity (allergy) to Gentamicin, Gelatin, Arginine, MSG. Yes No

Explain: _____

★ 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

Front Range Flu Shots, LLC • P.O. Box 1093, Littleton, CO 80160-1093 • Phone 303-797-3396
Federal Tax ID: 743077363

Influenza Type	Trivalent Shot	Quadrivalent Shot	Fluzone High Dose Shot	FluMist Nasal Spray	Amount Paid
Service Location:	60	60	60	60	
Diagnosis Code: ICD-9	V04.81	V04.81	V04.81	V04.81	
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23	
Vaccine Admin. Code:	90471	90471	G0008	90473	$_____
Vaccine Code:	90658	❑ 90686 (S) ❑ 90688 (M)	90662	90672	$_____ $_____
Clinic Location:					

Do not write below this line.

Injection site (0.50mL)
____ Left Deltoid
____ Right Deltoid
Intra-nasal (0.2mL)
____ Nasal Spray

VIS Provided: Inactivated Influenza Vaccine 08/07/2015
Live Attenuated Influenza Vaccine 08/07/2015

RN _____ Date _____

Mfg

Lot #

Exp. Date

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