(FLU) INFLUENZA IMMUNIZATION CONSENT FORM AND MEDICARE Billing CONSENT FORM

Name _____
First, Middle, & Last (Please Print) **(If Medicare Card, please print as name appears on card)**

Address: _____ Home Phone_____

City_____State_____Zip_____ Cell Phone_____

Date of Birth_____ Age_____ Social Security #_____

Insurance/Medicare Number_____

Primary Doctor_____

Are you Pregnant? Yes_____ No_____

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement" (VIS) and ask that the flu vaccine be given to me or the person named for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process this claim. I request the payment of benefits to the Mitchell County Health Department.

I understand I am responsible for payment if this vaccination is not paid for by my insurance.

_____ Date_____
Signature required

OFFICE USE ONLY

Date of Injection_____Site: IM RD IM LD IM LVL IM RVL

Clinic Site: Hlth. Dept. CC GE Tipton Hunter

other_____

_____ MDV

_____ FluBlok

Nurse Signature & Title_____

_____ High Dose

_____ 0.5 ml Syringe