2017-2018 FLU VACCINE Registration Form

Bill Insurance/Bill Individual

HCMC www.HCMC.org **MVNA** www.MVNA.org

Clinic Number: 42021

Employer/Name of Clinic Location: Providence Academy

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

(Legal name) Last Name **First Name** **Middle Name**

Date of Birth (MM/DD/YYYY) **Age** **Sex(M/F)** **Phone Number** ☐**Home or** ☐**Cell** **SSN – last 4 digits**

Address

City **State** **Zip Code**

Vaccine Choice	Billing Options		
☐ Quadrivalent Shot ☐ High Dose- 65 years and older only	**Cash Prices** ☐ Quad Shot - $38 ☐ High Dose - $65	☐ Cash ☐ Check #_____ Total $ Collected _____	☐ MnVFC – Must be 18 or younger AND one of the following: (Select category) ☐ American Indian/Alaskan Native ☐ Uninsured ☐ MA, MHCP, or MNCare

MVNA/HCMC can bill through any insurance. Please note, it is the individual's responsibility to check their coverage with their provider.

(#1) Primary Insurance Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Name

Secondary Insurance ID#

Group #

Policy Holder: ☐ **Self (skip section below)** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Check if applicable:

☐ Same Address as Patient

☐ Same Phone as Patient

Policy Holder Demographics – Complete if different than individual receiving vaccination:

Policy Holder Last Name **First Name**

Daytime Phone Number **Date of Birth (MM/DD/YYYY)**

Address

City **State** **Zip Code**

ONLY complete this box if patient is under 18 years of age:

Who is responsible for the bill?

☐ Same as Policy Holder

☐ Other: (If other, must complete information below)

Full Name:_____

Address:_____

_____

Phone:_____

Relationship to patient:_____

COMPLETION REQUIRED BY PATIENT

Please complete the following six questions	
Attention: If you answer yes to any of the questions, further assessment is needed by the nurse.	
1. Is this the first flu vaccination ever for the person to be vaccinated?	☐Yes ☐No
2. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	☐Yes ☐No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
4. Has the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	☐Yes ☐No
5. Has the person to be vaccinated ever had a serious reaction after receiving a vaccinations?	☐Yes ☐No
6. Is the person to be vaccinated 65 years of age or older?	☐Yes ☐No

I have received, read, and understand the current Flu VIS for the Vaccine provided by Hennepin Health Systems dba MVNA. I have had an opportunity to ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly consent, request and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. If I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release Hennepin Health Systems dba MVNA, its officers, employees, agents; and Providence Academy, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of Hennepin Health Systems dba MVNA's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by Hennepin Health Systems dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to Hennepin Health Systems dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Parent/Guardian Signature: 6 months – 17 years: _____

Print Name _____ **Relationship to Patient** ☐ **Mother** ☐ **Father** ☐ **Other**

I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

Client Signature: 18 and older _____ **Date:** _____

Print Name _____

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
Fluzone/Sanofi **Quadrivalent**	☐ 0.25 ml	**6 – 35 months**	Anterolateral Thigh: **L or R** IM Deltoid: **L or R**		
Fluzone/Sanofi **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
FluaLaval/GSK **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
HighDose Fluzone/ Sanofi	☐ 0.5 ml	65 years & up	IM Deltoid: **L or R**		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ___/___/2017

Vaccine Information Statement (VIS) offered to client: ☐ (RN to check box) VIS Edition: ___/___/___