PLEASE BRING THIS FORM WITH YOU TO THE CLINIC

Waveny LIFECARE NETWORK

Visiting Nurse & Hospice of Fairfield County
a member of Waveny LifeCare Network

2023 SEASONAL INFLUENZA IMMUNIZATION CONSENT FORM

22 Danbury Road | Wilton, CT 06897 | 203.762.8958

EIN #061062903 | DX CODE: 223

NAME - print (as it appears on insurance card)	GENDER ☐ M ☐ F	DOB ___/___/____	AGE
EMAIL ADDRESS			
ADDRESS	CITY, STATE	ZIP	PHONE

Please bring a copy of your insurance card to the clinic

INSURANCE (primary) - please circle the plan to be billed	INSURANCE ID (primary)
Medicare Part B Aetna Managed Medicare Anthem/Blue Cross Blue Shield	Relationship to insurance plan holder ☐ self ☐ spouse ☐ child
Name of Plan Holder	Plan Holder Date of Birth __/__/___

INSURANCE (secondary) - please circle the plan to be billed	INSURANCE ID (secondary)
Medicare Part B Aetna Managed Medicare Anthem/Blue Cross Blue Shield	Relationship to insurance plan holder ☐ self ☐ spouse ☐ child
Name of Plan Holder	Plan Holder Date of Birth __/__/___

SELF PAY *Insurance claims are to be reimbursed to patient directly. Please pay by check payable to VNHFC.*

Please answer the following questions and discuss any concerns with the nurse.

1. *Have you ever had a severe reaction to the influenza vaccine?* ☐ *Yes* ☐ *No* ☐ *Unsure*
2. *Do you have a fever of >100° F or feel moderately ill today?* ☐ *Yes* ☐ *No* ☐ *Unsure*
3. *Have you ever had Guillain-Barre Syndrome (severe paralytic illness)?* ☐ *Yes* ☐ *No* ☐ *Unsure*

Acknowledgment and authorization - I authorize Waveny-Visiting Nurse & Hospice of Fairfield County (VNHFC) records to be released and reviewed by an authorized representative of my third-party payer or employer as required for payment. I authorize this information to be released and reviewed by any federal or state agency only as required by the regulatory or licensing body of the agency. I agree to release and hold harmless VNHFC, the Town of Wilton and the venue at which the vaccine is being provided, and their respective employees, officers, elected and appointed officials, directors and affiliates from and all claims, actions, lawsuits and liability that might arise from or is in any way connected with this vaccine. I understand that if I experience any side effects, it is my responsibility to consult my physician at my expense. VNHFC Privacy Policy is available to me on the VNHFC website. I have been provided with the CDC Vaccine Information Statement (VIS Dated: 8/6/21) as a part of the registration process. I will have the chance to ask questions before vaccination. I understand the risks and benefits of the influenza vaccine to be given to me or the person I am authorized to make this request. I give VNHFC permission to notify my Primary Care Provider that I have received the vaccine. I understand VNHFC will submit my claim ONLY to insurance providers that VNHFC contracts with for this service and I am responsible to reimburse VNHFC for any charges, co-pays and deductibles not covered by my employer, Medicare, or health insurance. If for any reason my claim is denied, I will be billed for this service.

PATIENT SIGNATURE	DATE

STAFF USE ONLY

☐ _____ ☐ _____ ☐ _____

ADMINISTERED BY:	DATE ADMINISTERED:	Site: L Deltoid L Thigh R Deltoid R Thigh	LOT #/Exp. Date: