GetA*FluShot*.com

A Professional Health Care LLC Company, Established 1989
Community Immunization Provider since 1991

Insurance Claim Form and Consent Tdap Immunization

Check all insurance plans: ❑ **Uniform Medical Plan** ❑ **Regence BlueShield of WA** ❑ **Asuris NW Health**

❑ **Group Health Cooperative** ❑ **Premera** ❑ **LifeWise**

Patient Information (PLEASE PRINT name as it appears on insurance card)

Insurance ID Number: Group Number:

Last Name:	First Name:	**middle initial**

(Month/Day/Year)

Date of Birth: Phone #: ( )

Mailing Address: Gender: ❑F ❑M

City: State: ZIP Code:

I have read/had explained to me the Vaccine Information Statement about tetanus, diphtheria & pertussis and the Tdap vaccine. I have had a chance to ask questions and had them answered to my satisfaction. I believe I understand the benefits and risks of Tdap vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither GetAFluShot.com nor its sponsor or host site shall have any responsibility or liability if I suffer any other adverse reaction, following administration of the vaccination. I understand that I am responsible for payment for the vaccine if my insurance carrier denies payment.

X Signature of responsible person: _____ Relationship: _____ Date: _____

Community Provider/Health Plan Use Only for Tdap

Federal Tax ID: 91-1754065 Service Location: 60
Practice NPI # 1528244282 Provider NPI# 1558496158
CPT Code (vaccine): 90715 CPT Code (admin): 90471
Diagnosis Code: V04.81

Clinic Use Only

Clinic Location: _____

Date of Tdap Vaccination: _____

Mfr/Lot#: _____ Exp. Date: _____

Nurse's Initials: _____ Site of Injection: **L R Deltoid**

Please remit to: GetA*FluShot*.com 135 SE 102nd Ave Portland, OR 97216
(503) 258-9800 or (877) 358-7468

GAFS 5/12

Please complete both sides of this form

8/1/03

Get A Flu Shot.com Tdap Health Screen

Tetanus/diphtheria/pertussis (Tdap)

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1. Have you ever received the Tdap vaccine? This vaccine is needed once in lifetime.
☐ **Yes** ☐ ☐ **No**

2. Do you have a current moderate or high fever; or moderate or severe illness?
☐ ☐ **Yes** ☐ ☐ **No**

3. Do you have an allergy to latex or any component of the vaccine? (Please discuss with the nurse) ☐ ☐ **Yes** ☐ ☐ **No**

4. Have you ever had a serious reaction, severe swelling, severe pain, or a neurological disorder including seizures or gone into a coma after receiving a vaccination including DTP, DTaP, DT or Td vaccine? ☐ ☐ **Yes** ☐ ☐ **No**

5. Do you have a history of Guillain-Barre' Syndrome or active neurologic disorder? (e.g. Multiple Sclerosis, epilepsy, etc) ☐ ☐ **Yes** ☐ ☐ **No**

6. Are you currently under a physician's care for immunosuppression, disease of the blood, being treated for cancer? ☐ ☐ **Yes** ☐ ☐ **No**

7. FOR WOMEN: Are you pregnant and/or think you might be pregnant or breastfeeding? ☐
☐ **Yes** ☐ ☐ **No**

Notice of Privacy Practices: The information on this consent form is the extent of information Get A Flu Shot.com has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Any other release would require your authorization.

Name _____

Signature _____ Date _____

Please complete both sides of this form

8/1/03