KGH PHYSICIAN CLINICS
INFLUENZA (FLU) VACCINE
2013- 2014 SEASON

I have read the information provided about influenza and the Influenza Vaccine. I have had an opportunity to ask questions and I understand the benefits and risks for this vaccine. I consent to the administration of the Influenza Vaccine for myself or the person listed below for whom I am legally responsible for.

Person to receive vaccine:

Clinic/Site:_____

_____
Patient Name (please print)

_____
Guarantor (if different from Patient/please print)

Who is your Primary Care Provider:_____

_____
SSN DOB Sex

_____
Address

_____
City State Zip

_____
Home Phone Number Work Phone Number

If you are an established patient within our KGH Physician Clinics network, please present your card to the Receptionist and we will bill your insurance.

If you are NOT an established patient within our KGH Physician Clinics network, please be prepared to remit your $30.00 payment today.

By remitting your payment today and signing below, you understand that we will not bill your insurance company unless you are an established patient with KGH Physician Clinics: (exception: Regular Medicare recipients).

_____
Patient/Guarantor Signature

_____
(Relationship, if other than the Patient)

Circle Pmt Type: Cash Check-ck#_____
Important: ***must write ck#***
Bankcard: VISA, Master Card, Amex or Discover

For Office Use Only:

Date of Vaccination:____/____/_____ Pt Temp:_____

Allergies to: Thimerasol Yes____ No ____
Eggs Yes____ No ____
Other Yes____ No_____

If patient answered "yes" to "other", please list the other allergies:_____

Are you Pregnant?: Yes_____ No_____

Manufacturer:_____ Lot #:_____

VIS Publication Date:___/____/____Site of Injection: _____

Administered by:_____ Title:_____
(Signature Required) (RN, LPN, MA, MD)

Patient Check Out Time:_____

Patient Billing Information:

Non-Established Patients Only:
If you present for a Flu Vac and you are not established with any of our clinics, you would be responsible to pay for your Flu Vac at time of service. If you plan to submit your receipt to your insurance company for reimbursement, they may not reimburse you. If your insurance company requires us (the physician's office) to bill for your reimbursement, due to your non-established status with us, we will NOT be able to bill your claim for you. **Initial:**_____
Patient/Guarantor

Non-Established Medicare Patients Only:
If you present with a Regular Medicare Insurance card, we will bill your insurance. In the event that your claim is denied, you will be billed for services rendered. Denials are usually due to patient's enrollment in Medicare Advantage Plans, thus you (the patient) no longer participates in the Regular Medicare Program. If a denial is received from Medicare, you would be responsible to pay for your Flu Vac charges.
Initial:_____
Patient/Guarantor