

Beaufort County Health Department Statement of Permission and Assignment: Influenza Vaccine

Name: _____
Last
First
Middle

Gender: (circle) Male Female Date of Birth: _____ Social Security Number: _____

Address: _____

City _____ State _____ Number & Street _____ Zip _____

Phone #: Home _____ Work/Other _____ Primary Language: (circle) English Spanish Other

Race: (circle) White Hispanic African American Asian Native American Other

Insurance Information

Medicaid Medicaid ID # _____

Medicare Medicare Claim Number: _____

No Insurance

Private Insurance Name of Insurance Company: _____

Policy # (or Subscriber ID#) _____

Group/Plan Name: _____ Group #: _____

Pre-Vaccination Evaluation

I have read and understand the information provided to me about receiving vaccines for influenza (Current VIS form) and have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason to not receive the vaccination for influenza. Please let us know if you

- 1) Have had an allergic reaction to eggs
- 2) Have had a serious reaction (including Guillan-Barre' Syndrome) after receiving influenza vaccine
- 3) Have a fever with a temperature above 100 degrees?

Signed Patient Consent

By Signing Below: I hereby acknowledge a copy of the "Notice of Privacy Practices" for the Beaufort County Health Department was available for me to read and/or receive a copy. _____ **(Please Initial)**

I authorize the Beaufort County Health Department to submit a claim on my behalf (if applicable) to Medicare, Medicaid, and/or private insurance or other third party payor. I also authorize release of any information necessary in processing my claim. I request payment be made to the Beaufort County Health Department on my behalf. **I am aware if my insurance does not pay I will be responsible for the bill.**

Signature: _____ **Date:** _____

FOR HEALTH DEPARTMENT USE ONLY

<input type="checkbox"/> Fluzone (Private) U8863DA Pres-free <input type="checkbox"/> Fluzone (Private) UT8770JA Pres-free <input type="checkbox"/> Fluzone (Private) UT8820AA HD <input type="checkbox"/> Fluzone (Private) UT8794BA HD <input type="checkbox"/> Fluzone (Private) U88861JA Pres-free <input type="checkbox"/> Fluzone (State) U8881DA Pres-free <input type="checkbox"/> Entered in Patagonia <input type="checkbox"/> Entered in NCIR	<input type="checkbox"/> Date _____ Given By _____ RN # _____ Administration Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid Diagnosis Code Z23 Pres-free Dosage and CPT Codes: <input type="checkbox"/> 0.50 ml CPT 90656 Presfree <input type="checkbox"/> 0.50 ml 90688 <input type="checkbox"/> 0.50 ml CPT 90662 (High Dose)
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