

Last Name – Please print clearly	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age
Street Address	City	State	Zip Code	Home/ Cell Phone Number	

**For Care, Payment and Operations:** This allows us to coordinate your care with other healthcare providers and to bill for our services. This also allows your health plan to process your claims and provide services to you. Immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law.

**Assignment of Benefits and Responsibility for Payment:** This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan. I authorize Homeland Health Specialists, Inc. to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. **I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co insurance.**

<b>Payment Information</b>			<b>Attach a copy of your insurance cards to the consent.</b>		
1 <sup>st</sup> Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number			
2 <sup>nd</sup> Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number			
<input type="checkbox"/> Cash Payment	<input type="checkbox"/> Company Payment				
\$	Company Name:				

**Health History**

- Yes No
- 1. Is this your first flu shot ever?
  - 2. Have you ever had a reaction to a flu vaccine that needed immediate medical attention?
  - 3. Are you allergic to eggs?
  - 4. Are you sick today? (Fever of 100.5 or higher on the day of clinic?)
  - 5. Have you ever had Guillain-Barré syndrome (GBS)?

**SIGNATURE AND ACKNOWLEDGEMENT**

I have read and understand the current Vaccine Information Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I understand that I may revoke or cancel this consent in writing at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

_____ Signature of Patient or Legal Guardian	_____ Today's Date	_____ Staff Verification
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**FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW**

<p><b>VACCINE</b></p> <p>Manufacturer: _____          Trade Name: _____          Quadrivalent          Dose: _____          Lot #: _____          Expiration Date: _____          Dx code: Z23</p>	<p><b>VACCINATOR</b></p> <p>Administered by: _____          _____</p> <p>Date Administered and VIS provided: _____          _____</p>	<p><b>ADMINISTRATION</b></p> <p><b>Intramuscular Injection Site</b></p> <p><input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid</p> <p><b>For children &lt;35 mo</b></p> <p><input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh</p> <p><b>Date of VIS: 08/07/2015</b></p>
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