Circle One
6WXGHQW)DFXOW\ (PSOR\H

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive ” 1R VHYHUH DOOHUJLF UHDFWLRQV 7R HJJ RU YDFFLQH ” 1R KLVWRU\ RI *XLOODLQ %DUUH 6\QGURPH ” 1R IHYHU

ODWH[” 'RHV QRW KDYH D EOHHGLQJ GLVRUGHU

[redacted]

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for service provided by them.

ACKNOWLEDGEMENT

KDYH UHDG DQG EHHQ RIIHUHG D FRS\ RI WKH ,QIOXHQ]D 9DFFLQH ,QIRUPDWLRQ 6WDWHPHQW SULRU WR P\ YDFFLQDWLRQ
DOO WKH ULVNV DQG EHQHILWV DQG KDYH KDG D FKDQFH WR DVN TXHVWLRQV ,I , DP LQ WKH YDFFLQDWLRQ DUHD
YDFFLQDWLRQ ,I , KDYH DQ\ TXHVWLRQV , XQGHUVWDQG WKDW , PD\ H[SHULHQFH VLGH HIIHFWV LW ZLOO EH FRPPRQ
P\ SK\VLFLDQ DW P\ H[SHQVH ,I , H[SHULHQFH VRUHQHVV UHGQHVV DQG RU VZHOOLQJ DW WKH LQMHFWLRQ VLWH
LQFOXGHG D EDFN LPPXQH SODLQ IHYHU RU RWKHU LOOQHVV , DP DZDUH WKDW %DUUH 6\QGURPH
DQDSK\OD[LV ,I , KDYH DQ\ TXHVWLRQV 9$ 1DWLRQDO 9DFFLQH ,QMXU\ &RPSHQVDWLRQ DJHQWV
DIILOLDWHV RIILFHUV RU HPSOR\HHV RI DQ\ NLQG ZKHWKHU NQRZQ RU XQNQRZQ
RXW RI RU LQ FRQQHFWLRQ ZLWK WKH DGPLQLVWUDWLRQ RI WKH YDFFLQH

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RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

First Name **MI** **Last Name**

Address Number **Street Name** **Gender M/F/Other**

City **State** **Zip Code**

Age **Date of Birth** **Area Code** **Phone Number**

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Email (optional)

Race: Ǐ :KLWH $IULFDQ $PHULFDQ %ODFN $PHULFDQ ,QGLDQ 3DFLILF ,VODQGHU 7ZR RU 0RUH 5
Ethnicity: ‘ +LVSDQLF ‘ 1RQ +LVSDQLF /DWLQR

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

Ǐ **Aetna** Ǐ **Anthem/Blue Cross Blue Shield** Ǐ **Cigna** Ǐ **Humana** Ǐ **HealthLink** Ǐ **WellFirst (SSM)**

Ǐ **UHC** Ǐ **UMR** Ǐ **AllSavers** Ǐ **GEHA** Ǐ **GoldenRule** Ǐ **TriCare________** Ǐ **Medica**

Medicare Plans: Ǐ **Medicare Part B** Ǐ **Anthem/Blue Cross Blue Shield** Ǐ **Essence**

Medicare Advantage Plan: Ǐ **Aetna PPO** Ǐ **Cigna PPO** Ǐ **Coventry PPO** Ǐ **HealthLink PPO** Ǐ **Humana PPO** Ǐ **UHC PPO**

Subscribers Name:____________________ **Subscribers D.O.B. ____/____/____** **Relationship to subscriber:_______________**

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

BBBBBBB BBBBBXBB BBBBBBB ____/____________________

'DWH 6LJQDWXUH 3DWLHQW RU /HJDO *XDUGLDQ 5HODWLRQVKLS WR 3DWLHQW

INSURANCE MBR ID

ξ **Cash** ξ **Check # _______________** ξ **Bill** ξ

Clinic ID#	**X** B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B **Nurse Signature** **Date Given**	**0.5 ml Lot Given** **A B C D** **E F G**	**IM Site Given** **Deltoid” Thigh** **L ŏ R**

”5HYLVHG6$,17/28,681,9(56,79(56,21