VaxCare

VaxCare has partnered with your healthcare provider to provide immunizations.

All bills for immunizations will come from VaxCare and its physicians.

Partner ID: 117627

Partner Name: Morehead State University

Ship to ID: 1236232

Clinic ID

Patient ID

FLU OUTREACH

Consent ID:

TO BE COMPLETED BY PATIENT - BLACK INK ONLY - WRITE IN ALL CAPS

PATIENT FIRST NAME **(as it appears on insurance card)** | MI | PATIENT LAST NAME **(as it appears on insurance card)** | DATE OF BIRTH (MM▪DD▪YYYY) | GENDER: ☐ M ☐ F

ETHNICITY: ☐ Amer. Indian / Alsk. Native ☐ Asian ☐ Black / Afr. Amer. ☐ Hawaiian / Pac. Islnd. ☐ Hispanic ☐ White ☐ Other_____

STREET ADDRESS | APT/SUITE | CITY | STATE | ZIP

HOME OR PRIMARY PHONE | SOCIAL SECURITY NUMBER | GUARDIAN FIRST NAME (if patient is a minor) | GUARDIAN LAST NAME

Payment and Insurance Information (Please complete information relevant to only one payment method)

☐ INSURANCE PAY

Please fill in the circle to the left of your primary insurance name.

- ◯ AARP Secure Horiz
- ◯ Aetna
- ◯ All Savers
- ◯ Anthem BCBS
- ◯ BCBS Federal
- ◯ Bluegrass Fam Hlth
- ◯ Centercare
- ◯ CIGNA
- ◯ Golden Rule
- ◯ Great West-CIGNA
- ◯ HealthLink
- ◯ Humana
- ◯ Kentucky Health Coop
- ◯ Medicare B
- ◯ Medicare Railroad
- ◯ Multiplan
- ◯ Three Rivers
- ◯ Tricare North
- ◯ UMR
- ◯ UMWA
- ◯ United Healthcare

PRIMARY INSURANCE

MEMBER ID# | GROUP ID#

PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Dependent

INSURED FIRST NAME | INSURED LAST NAME | INSURED DOB (MM▪DD▪YYYY) | GENDER: ☐ M ☐ F

SECONDARY INSURANCE

SECONDARY INSURANCE NAME | SECONDARY MEMBER ID# | SECONDARY GROUP ID#

PATIENT'S RELATIONSHIP TO SECONDARY INSURED ☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURED FIRST NAME | SECONDARY INSURED LAST NAME | SECONDARY INSURED DOB (MM▪DD▪YYYY) | GENDER: M F

☐ PARTNER BILL — INSURANCE NAME

☐ SELF PAY — AMOUNT $ | CASH ☐ | CHECK ☐ | CREDIT CARD ☐

All funds for self-pay patients should be paid at the time of service and NOT remitted to VaxCare.

☐ EMP PAY — EMPLOYER ID# | EMPLOYEE ID# | EMPLOYER NAME

☐ NO PAY ☐ NP / INDIGENT ☐ PARTNER EMPLOYEE

Authorization and Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

SIGNATURE of PATIENT or LEGAL GUARDIAN | DATE

FOR OFFICE USE ONLY - BLACK INK ONLY

Vaccination Details (Lot number must be recorded. Please adhere label or print clearly.)

- ☐ Prefilled Syringe 0.5 mL (36 mths & older)
- ☐ Intradermal PFS 0.1 mL (18-64 yrs)
- ☐ High Dose PFS 0.5 mL (65 yrs & older)
- ☐ Multi-Dose Vial 5 mL (6 mths & older)
- ☐ Pediatric PFS 0.25 mL (6-36 mths)
- ☐ FluMist Nasal Sprayer 0.2 mL (2-49 yrs)

LOT#

SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other_____

DELIVERY: ☐ IM ☐ IN ☐ ID Other_____

ADMINISTRATOR SIGNATURE | DATE (MM▪DD▪YYYY) | ADMINISTRATOR ID

Nurse/Administrator: I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Sheets and appropriate Immunization Schedules, and has given verbal and written consent for vaccination(s).

For patients receiving a Fluzone Standard, Fluzone Pediatric, Fluzone High Dose or FluMist (Nasal) vaccination:

The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	☐	☐

***FOR PATIENTS RECEIVING A FLUMIST (NASAL) VACCINATION ONLY ***

Please complete the following additional questions.

	YES	NO
5. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐
6. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐
8. Is the person to be vaccinated receiving antiviral medications?	☐	☐
9. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐
10. Is the person to be vaccinated pregnant, or planning to become pregnant in the next month?	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐
13. In the past 12 months, has a health-care provider ever told the person being vaccinated that they had wheezing or asthma?	☐	☐

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(888) 829-8550 www.vaxcare.com