Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

CONSENT FOR TREATMENT INFLUENZA Immunization

✓ Please make checks payable to Front Range Flu Shots, LLC *or* FRFS.

Print legal name or as it appears on insurance card

Last Name	First Name	Middle Initial

Birthdate	MM	DD	YYYY	Age	❑ Male ❑ Female	Home Phone	Cell Phone

Home Address: Street City State Zip

This section is to be completed ONLY if we are billing your insurance.

Patient Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other

❑ Aetna ❑Cofinity* ❑Meritain*	Member ID: _____	Group #	_____
❑ Cigna	Member ID: _____	Group #	_____
❑ HealthPartners	Member ID: _____	Group #	_____
❑ Humana	Member ID: _____	Group #	_____
❑ Medicare Part B Primary Plan	Member ID: _____	Group #	_____
❑ Medicare Advantage Plan: _____	Member ID: _____	Payer ID	_____
❑ Rocky Mountain Health Plans	Member ID: _____	Group #	_____

*Cofinity or *Meritain provide Insurance Phone # _____ Claims Address _____

Co-payment may apply. We do not accept Cigna Connect Network, Humana HMOX or Kaiser.

Answer the following questions, sign and date below:

1. Have you ever had a flu immunization before? Yes No
2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No
3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No
4. Do you currently have a fever, or moderate or severe acute illness with or without fever? Yes No
5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No
6. Have you ever had a bad reaction to any other vaccine? Yes No

Explain any adverse or allergic reactions: _____

★ The current applicable CDC *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRFS) shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the influenza vaccine.

★ **Notice of Privacy Practices:** The information on the consent form is the only information FRFS has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of *Notice of FRFS's Privacy Practices*.

★ I understand that I am responsible for payment to FRFS if vaccination is not fully covered by insurance company and there is a $25 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding and Billing Information for Influenza Vaccination				
Front Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120 Phone 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363				
Influenza Type	**Quadrivalent Shot**	**Quadrivalent Flucelvax Shot**	**Fluzone High Dose Shot**	**Amount Paid**
Service Location:	60	60	60	
Diagnosis Code: ICD-10	Z23	Z23	Z23	
Vaccine Admin. Code:	90471	90471	G0008	$_____
Vaccine Code:	❑ 90686 (S)	❑ 90674 (S)	90662	$_____
	❑ 90688 (M)	❑ 90756 (M)		$_____

Do not write below this line.	
Injection site (0.50mL) ____ Left Deltoid ____ Right Deltoid	VIS Provided: Inactivated Influenza Vaccine 08/07/2015 RN _____ Date _____ Mfg Lot # Exp. Date

Clinic Location: _____

Aetna CIGNA Cofinity DCSD HP Humana MC MEDADV Meritain RMHC Comp CreditCard Check#_____ Cash _____ Invoice_____

CC Email: Name Card Type No# Exp. Date Security Code Zip Code 8.12.18