

- This form is two sided -



Hennepin Healthcare
MVNA

**2018-2019 FLU VACCINE
Bill Insurance/Bill Individual
Registration Form**

Clinic Number: _____
Employer/Name of Clinic Location: _____

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

Last Name

 First Name

 Middle Name
 _____ SSN - last 4 digits

 Sex (M/F) Date of Birth (MM/DD/YYYY) Age

 Address

 City

 State Zip Code

 Phone Number Home or Cell

Payment Options:

<input type="checkbox"/> Bill Insurance *Accurate & complete information below is required for successful billing	<input type="checkbox"/> Pay Cash or Check Discounted Cash prices: Quad: \$38 High Dose: \$65 FluMist: \$43 Check # _____	<input type="checkbox"/> Grant Covered *Any uninsured minors qualify *Adults may qualify at pre-arranged clinics
---	---	---

Hennepin Healthcare/MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

(#1) Primary Insurance Company Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Company Name

Secondary Insurance ID#

Group #

Complete this box if the patient is under 18 years of age:

Please provide parent/guarantor info below.

Same as the Policy Holder (must fully complete Policy Holder box)

Other: (If other, must complete information below)

Full Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Relationship to patient: _____

Policy Holder/Subscriber:

Self (skip section below) Spouse Parent Other _____

Policy Holder Last Name

First Name

Policy Holder Date of Birth (MM/DD/YYYY)

Daytime Phone Number Same Phone as Patient

Policy Holder Address Same Address as Patient

City

State

Zip Code

Please complete the following questions		Form Reviewed by:
Attention: If you answer yes to any of the questions, further assessment is needed by the nurse.		
1. Does the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the person to be vaccinated already received the flu vaccine this flu season?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?		<input type="checkbox"/> Yes <input type="checkbox"/> No
FLUMIST ONLY: Only answer #6-15 if you are interested in receiving the FluMist Nasal Spray		
6. Is the person to be vaccinated younger than 2 years old or 50 years of older?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does the person to be vaccinated have any of the following: HIV, Cancer, organ or bone marrow transplant, rheumatoid arthritis, Chron's disease, multiple sclerosis, Lupus, psoriasis, or reduced immune activity?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the person to be vaccinated take any medication that affects the immune system such as prednisone, azathioprine (Imuran), cyclosporine, methotrexate, rituximab, Orenzia, or Remicade?		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has the person to be vaccinated received any vaccinations in the past 4 weeks?		<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the person to be vaccinated have active, untreated TB?		<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is the person to be vaccinated pregnant or you could become pregnant during the next month?		<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Is the Child between 2 and 4 years of age, and has been told they have wheezing or asthma in the past 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
15. If under 18, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No

I had an opportunity to review the CDC VIS for influenza vaccine and ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly authorize a nurse to administer the vaccine to me. I hereby release Hennepin Health Systems (HHS) dba MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of HHS dba MVNA's Notice of Privacy Practices is available to me, which provides an explanation of the way in which my health information may be used or disclosed by HHS dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to HHS dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Relationship to Patient: Self OR 6 months – 17 years Mother Father Other _____

Signature: _____ Date: _____

Print Name: _____

If not "self", I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

NURSE ONLY					
Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
FluLaval/GSK Quadrivalent	<input type="checkbox"/> 0.5 ml	<input type="checkbox"/> 6 months & up	IM Deltoid: L or R		
Fluzone/Sanofi Quadrivalent	<input type="checkbox"/> 0.5 ml	<input type="checkbox"/> 3 years & up	IM Deltoid: L or R		
HighDose Fluzone/ Sanofi	<input type="checkbox"/> 0.5 ml	<input type="checkbox"/> 65 years & up	IM Deltoid: L or R		
FluMist/ Medimmune	<input type="checkbox"/> 0.2 ml	<input type="checkbox"/> 2 to 49 years	Nasal spray		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ____/____/2018

Vaccine Information Statement (VIS) offered to client: (RN to check box) VIS Edition: ____/____/____