Patient's Name:

Disclosure and Consent of Influenza vaccine

Patient Name *

First Name Last Name

Date of Birth

Check ALL that apply:

I have never had a life-threatening allergic reaction to EGGS or EGG PRODUCTS or any known severe reaction to THIMEROSAL.

I am currently free of any known infectious illness (i.e. respiratory infection).

I have no known active neurological disorder.I have not been diagnosed with Guillain-Barre syndrome.

I have had a chance to ask questions about the disease that this vaccine prevents, the vaccine and how it is administered.

I have had an influenza vaccine before.I have never had a reaction to any previous influenza vaccine.

Patient Temperature:

Influenza Dx Code: Z23

Influenza Vaccines/CPT Code (Check One):

90662—Fluzone Quadrivalent High-Dose, Prefilled .7ml, for patients 65yrs & older
90756—Flucelvax Quadrivalent, Multi-Vial .5ml, for patients 4yrs & older
90688—Fluzone Quadrivalent,Multi-Vial .5 ml, for patients 6mo & older

Administration CPT codes (one to be applied in accordance with payer requirements):

G0008—Medicare Only

90471—>19 yrs of age (1st immunization)

90472—>19 yrs of age (Each additional immunization)

Patient's Name:

Insurance Agreement/Waiver (Check One):

I choose to file my insurance for this procedure. Verification by insurance that the vaccine is covered is not a guarantee of payment. If you would like the charges for this vaccine submitted to your insurance company (we must be listed as your primary care physician), sign and date below. Please be aware that both an administration and an influenza vaccine charge at a non-discounted rate will be billed to your insurance, possibly increasing your out of pocket expense if your insurance company denies the claim, does not cover the claim or applies the charges to your deductible. We will provide you with a receipt of payment if you wish to appeal to the insurance company for further reimbursement.

I choose not to file my insurance for this procedure and would like to pay a discounted fee for this vaccine and waive the submission of this procedure to your insurance company, please sign and date below.
90662 - $55.00per dose; 90685 - $25.00 per dose; 90756 - $30.00 per dose, and 90688 - $30.00.

Patient's Signature: Today's Date: