**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F Date of Birth: \_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**AS A COURTESY** we will bill your primary and secondary insurance carrier if you provide **ALL** the necessary information. **A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS**

**PRIMARY INSURANCE SECONDARY INSURANCE**

**Policyholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policyholder date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financially Responsible Party**

⃝ I am responsible for any amount not covered by insurance. Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⃝ **IF someone else is responsible for any amount not covered by insurance please list the responsible person’s name, relationship to patient and billing address on the back of this form.**

“I have read/have had read to me the information from the VIS form. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccines and ask that the vaccine be given to me, or the person named below for who I am authorized to make this request.”

I have received and/or read and understood the notice of Privacy Practice regarding the use and disclosure of health information for me and/or my child. I grant permission for the record to be released to my medical providers, health departments, schools, and day care centers.

I grant permission for HPH to release this record to my employer.

I authorize my insurance company to assign the amount payable under the client’s contract directly to Hancock Public Health. I understand that I am financially responsible for all the charges that are not covered under the insurance plan. I understand that I am financially responsible for any amount due if my deductible is not met as determined by my insurance company. I also understand that I am responsible for notifying Hancock Public Health if there is a change in the insurance coverage or funding status.

**Is the person to be vaccinated sick today? \_\_\_\_\_\_\_\_\_**

**Does the person to be vaccinated have an allergy to a component of the vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? \_\_\_\_\_\_\_\_\_\_**

**Has the person to be vaccinated ever had Guillain-Barré syndrome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have read/have had read to me and understand this form and have completed it to the best of my knowledge.**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date**  | **Manf. /Lot**  | **Route**  | **Site**  | **Nurse Signature**  |
|   |   | **IM**  |   |   |