HOMELAND HEALTH SPECIALISTS, INC. INFLUENZA CLAIM & CONSENT FORM - PLEASE PRINT ONLY

INSURANCE INFORMATION ~ PLEASE CHECK OFF ALL INSURANCE TYPES WHICH APPLY

Primary Insurance Plan: ☐ BCBS ☐ HealthPartners ☐ Medica ☐ Preferred One
☐ Medicare B ☐ Rail Road ☐ UCare ☐ Unicare ☐ Other Ins.
☐ PrimeWest ☐ Humana Gold ☐ Sterling Options ☐ MHP List: _____

Member ID Number:

Group / Account ID Number: I am the: ☐ Subscriber ☐ Dependent

DO YOU HAVE SECONDARY INSURANCE? ☐ Yes ☐ No

Secondary Insurance Plan: _____ Group:

Member ID Number:

PATIENT INFORMATION ~ PLEASE PRINT: ALL FIELDS ARE REQUIRED

Member Last Name:

Member First Name: Middle Initial:

Date of Birth: - - (i.e. MM-DD-YYYY) Gender: ☐ Male ☐ Female

Phone Number: - -

Street Address: Apt #:

City: State: Zip:

Subscriber Employer:

Today's Date: - - (MM-DD-YYYY) Registrar Initials

CONSENT & MEDICAL SCREENING INFORMATION (FLUMIST or INJECTION)

Are you sick today? ☐ Yes ☐ No	Are you pregnant? ☐ Yes ☐ No	How old are you?
Have you had a serious reaction to any vaccine? ☐ Yes ☐ No	Are you allergic to Eggs or Thimerosol? ☐ Yes ☐ No	What health conditions do you have?
Have you had Guillian-Barre Syndrome? ☐ Yes ☐ No	Do you live with anyone who is immunosupressed, on chemotherapy, has an autoimmune disease, or HIV? ☐ Yes ☐ No	_____ _____

I have received, read, and understand the "INFLUENZA VACCINE, WHAT YOU NEED TO KNOW" handout published and distributed by the U.S. Department of Health & Human Services, Center for Disease Control & Prevention, National Immunization Program. I have received and read the "Notice of Privacy Practices" handout. I understand how my medical information may be used and my rights under the Health Insurance Portability & Accountability Act of 1996. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of an influenza vaccination, and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.
I agree that neither Homeland Health Specialists, Inc., their officers, directors, staff, sponsors and/or agents shall have any liability if I contract influenza, or other respiratory diseases, or suffer any other adverse reaction following the administration of the flu vaccination.
I understand that the insurance information that I provided is current, accurate and complete. I understand my health plan will be billed for payment. I understand that if my health plan does not pay for my influenza vaccination that I am responsible for payment. I understand that I will be billed for payment at the contracted insurance rate. I understand that if I do not pay within 60 days my claim will be sent over to a collections agency. Charges may include a collection fee and interest at 8%, accrued monthly.
PATIENT SIGNATURE: _____ DATE: _____

*****PLEASE REMAIN ON PREMISES FOR 15-MINUTES FOLLOWING A VACCINATION*****

☐ Adventis Fluzone	☐ GSK Flulaval	☐ MedImmune FluMist Intranasal
Site of Injection:	☐ Left Deltoid	
Nurse Initials: _____	☐ Right Deltoid	Nurse Initials: _____