Circle One
6WXGHQW)DFXOW\ (PSOR\H

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive: 1R VHYHUH DOOHUJLF UHDFWLRQ WR HJJV RU DQ\ YDFFLQH FRPSRQHQW; 7KLV IRUP YDOLG IRU VHDVRQ

ODWH[HVV QRW KDYH VDEHDOWKSUREOHPV RU IHYHU ; 1R KLVWRU\ RI *XLOODLQ %DUUH 6\QGURPH

[redacted]

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for service provided by them.

ACKNOWLEDGEMENT

KDYH UHDG DQG EHHQ RIIHUHG D FRS\ RI WKH ,QIOXHQ]D 9DFFLQH ,QIRUPDWLRQ 6WDWHPHQW SULRU WR P\ LQIOXHQ]D YDFFLQDWLRQ

DQG WKH ULVNV DQG EHQHILWV WKDW KDYH EHHQ H[SODLQHG WR PH

YDFFLQDWLRQ DQG PD\ VXIIHU VLGH HIIHFWV

P\ SK\VLFLDQ DW P\ UHTXHVW

LQFOXGHG DV DWWDFKHG IRU WKH IOX YDFFLQH

DQDSK\OD[LV RU RWKHU VHULRXV UHDFWLRQ

DIILOLDWHV DQG FRQWUDFWRUV IURP DQ\ DQG DOO OLDELOLW\

RXW RI RU LQ FRQQHFWLRQ ZLWK WKH DGPLQLVWUDWLRQ RI WKH YDFFLQH

$//,1)250$7,21 %(/2: 72 5(&(,9(,1)/8(1=$ 9$&&,1(

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

First Name **MI** **Last Name**

Address Number **Street Name** **Gender M/F/Other**

City **State** **Zip Code**

Age **Date of Birth** **Area Code** **Phone Number**

Email (optional)

Race: :KLWH $IULFDQ $PHULFDQ %ODFN 1DWLYH +DZDLLDQ 3DFLILF ,VODQGHU $VLDQ 7ZR RU 0RUH

Ethnicity: +LVSDQLF 1RW +LVSDQLF /DWLQR

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

Aetna **Anthem/Blue Cross Blue Shield** **Cigna** **Humana** **HealthLink** **WellFirst (SSM)**

UHC **UMR** **AllSavers** **GEHA** **Golden Rule** **TriCare________** **Medica**

Medicare Plans: **Medicare Part B** **Anthem/Blue Cross Blue Shield** **Essence**

Medicare Advantage Plan: **Aetna PPO** **Cigna PPO** **Coventry PPO** **HealthLink PPO** **Humana PPO** **UHC PPO**

Subscribers Name:_______________ **Subscribers D.O.B. ____/____/____** **Relationship to subscriber:______________**

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

BBBBBBB BBBBBBBB BBBBBBB ________________________ /________

'DWH 6LJQDWXUH RI 3DWLHQW RU /HJDO *XDUGLDQ 5HODWLRQVKLS

INSURANCE MBR ID

Cash **Check # _______________** **Bill**

Clinic ID#	X B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B **B B B B B** **Nurse Signature** **Date Given**	**0.5 ml Lot Given** **A B C D** **E F G**	**IM Site Given** **Deltoid – Thigh** **L – R**