Flu Only Consent

PassportHealth

Participant Name (First)_____**(MI)**_____**(Last)**_____

If Under 18--Parent/Guardian Full Name & Phone _____
(Name) *(Phone)*

Personal Phone:_____ O **Mobile#** O **Home#** **Employer:** _____

Date of Birth: Month_____ Day_____ Year_____ **Age:** _____ **Gender:** _____

Mailing Address:_____
(Street or PO BOX) *(City)* *(State)* *(Zip)*

Email:_____

Insurance Information ***PLEASE ATTACH A COPY OF INSURANCE CARD***

1.) **Please write your** A.) **Primary Insurance** (ex: BCBS, Aetna, HealthChoice), B.) **Member ID #**, and C.) **Group # :**

A._____ **B.** _____ **C.**_____
Insurance Company Member ID # Group #

2.) Please include your A.) **Secondary or Supplementary Insurance,** B.) **Member ID #,** and C.) **Group # :**

A. _____ **B.** _____ **C.**_____
Insurance Company Member ID # Group #

3.) Is Participant the primary insured? O **Yes** O **No**

- **If NO, please list the Name and Date of Birth of the primary insured:**

Name: _____ **Date of Birth:** _____

Medical Questions & Consent

Initial below to receive flu vaccine and answer questions

____ **Flu Injection** - Answer 1-5

For flu vaccine, answer questions below	**YES**	**NO**
1. Are you sick today or have a high fever?	O	O
2. Do you have allergies to antibiotics, egg, gelatin, latex, yeast, or any vaccine ingredient?	O	O
3. Have you ever experienced a serious reaction after receiving a vaccination?	O	O
4. Have you experienced Guillain-Barre, swelling of the brain, seizure, or other nervous system problems *after* a vaccination?	O	O
5. **For Women:** Are you pregnant or trying to become pregnant?	O	O

Signature and Consent

I consent to the injection(s) marked and have had the opportunity to ask questions and receive a Vaccine Information Sheet (VIS) for any immunizations I am receiving today. I authorize my immunization record to be recorded with the OK State Health Department and released to employer, school, and/or physician if requested.

Participant Signature:_____**Date:**_____

Office Use Only

_____	_____	_____	_____	RA LA IM SQ	_____
Vaccine	**Manufacturer**	**Lot #**	**Exp Date:**	**Injection Site:**	**VIS Edition Date:**

Nurse provided immunization(s) to patient without difficulty and patient was observed showing no adverse reactions.

Nurse reviewed, administered injection(s), and VIS provided by:_____ **Date:**_____

Nurse NOTES:

OKC: 3330 NW 56th St. # 106 OKC, OK 73112
Broken Arrow: 1615 Eucalyptus Ave. # 206 Broken Arrow, OK 74012

PassportHealth

Patient Financial Responsibility Policy

Most insurances cover the cost of vaccines and other wellness services. However, in some cases you may be responsible for some or all of the cost including a co-pay, co-insurance, or deductible amount, or if your insurance is not currently active. It is your responsibility to know what your insurance covers and if it is currently active.

Denials

If a claim is denied, we will research why the rejection occurred and attempt to resubmit the claim. If the denial cannot be resolved or if the claim is denied a second time, the appropriate balance becomes the responsibility of the patient. You may then contact your insurance company for reimbursement.

Children who are Uninsured or Covered by Medicaid (SoonerCare)

The state of Oklahoma will cover the cost of vaccines for children who are uninsured or covered by Medicaid. They do not cover the cost if either parent has private insurance. Please be sure to include all insurance information for both parents or guardian(s) as well as the child's SoonerCare number so the claim can be appropriately processed.

Payment by Check

If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $15.00

By signing below, you attest that you have provided your current insurance information and allow Passport Health of Oklahoma to provide the insurance company information necessary to file a claim. You also agree to facilitate payment of claims by contacting your insurance carrier when necessary. You signify understanding that you responsible for any costs not covered by your insurance, including co-payments, co-insurance or deductible amounts.

Printed Name of Patient/Parent/Guardian:_____

Signature: _____ Date: _____

Passport Health of Oklahoma
Oklahoma City: 3330 NW 56th St. #106 OKC, OK 73112 (405-563-8961)
Tulsa: 1615 Eucalyptus Ave. #206, Broken Arrow, OK 74012 (918-770-4290)