MARGARET MARY HEALTH

Staff – Consent for Flu Vaccine

Legal Last Name:		Legal First name:	Sex: M F	Date of Birth: / /
	School:	Doctor:	Home/Cell Phone:	
Address:		City:	St:	Zip:

1. Have you ever had a severe, life-threatening allergic reaction to a previous flu vaccine? Allergic reaction: hives, rash that covers body, difficulty breathing, etc. ❒This is the first time I have ever received a flu vaccine **Yes No**

2. Do you have a severe, life-threatening allergy to eggs? **Yes No**

3. Have you ever had Guillain-Barre syndrome? (A rare nerve disorder that can cause paralysis) **Yes No**

4. Please write in insurance information.

Subscriber's Legal Name:
(person who actually has the insurance) _____ Subscriber's Date of Birth: _____

Insurance Name: _____ Policy #:_____ Group #:_____

Subscriber's address: _____ City:_____ St:_____ Zip:_____

Consent to Vaccinate: I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for each vaccine I will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each vaccine. **Consent to Treat:** I hereby request and authorize MMH-employed physicians and their staff to administer immunization(s) to me. I authorize staff to perform various serum tests on a sample of my blood in the event that a health care worker has accidently been exposed to my blood or bodily fluids. **Release of Information:** I authorize MMH staff to release information that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. **Assignment of Benefits:** I hereby authorize payment directly to MMH in return for rendering the services described herein. **Privacy Practices:** I understand that the MMH Joint Notice of Privacy Practices provides information about how MMH may use and disclose protected health information. By signing this form I acknowledge that I have either: (a) received and reviewed a copy of the Notice via hard copy or email; or (b) have been offered an opportunity to receive the Notice but do not wish to do so. A copy of the Notice can be requested at any time by contacting (812) 933-5291. **Financial Responsibility:** I acknowledge and agree that: (i) I am legally responsible for this account and all costs associated with the collection of this account; (ii) account balances after insurance must be paid in full within thirty (30) days of patient billing, unless other payment arrangements have been made, to avoid collection placement; (iii) any costs or expenses we incur to collect payment from you, including collection fees, attorney fees or other fees will be added to any outstanding balance; and (iv) there will be a $25.00 service charge on all returned checks. **Release:** I knowingly and voluntarily assume all risk in connection with my receipt of an immunization. I hereby release MMH, its directors, officers, physicians, employees and agents from any and all liability or claim for damages arising from or related to such immunization. I further acknowledge that no guarantees have been made to me as to the results of an immunization and that it is solely my responsibility to follow up with a physician for any medical diagnosis, examinations, advice or treatment.

5. _____ **Signature** _____ **Date**

Office Use Only:

Funding Source: Insurance
Manufacturer: GSK
Lot #: C54L3
Exp date: 6-30-17
VIS dated: 8-7-15

Date administered:

Administered IM by:

Deltoid: Left Right