TriState Health

# INFLUENZA VACCINATION REGISTRATION INFORMATION

## Patient Information

Date of Service ____/____/_______

Patient Name ______________________________________ Sex _________ Age _________ Date of Birth ____/____/______

Mailing Address ________________________________________ City ____________________ State _____ Zip ____________

Phone # _____________________ Phone Type _____________ Email ____________________________________________

Primary Care Provider ____________________________________________________________________________

## Gaurantor Info

Guarantor Name____________________________________________ Relation to Patient _____________________________

Date of Birth ____/____/_______ Phone # _____________________ Phone Type _____________

Insurance Card Copied ❑ Yes ❑ No

## Financial Policy

- Charges will be billed to the responsible patient/guarantor's insurance company only if you provide current and accurate insurance card at the time services are rendered.
- Guarantor will be responsible for any unpaid balance, if applicable, and must pay upon receipt of Explanation of Benefits (EOB) or upon receipt of invoice from TriState Health
- We accept cash, check, and credit/debit card for any outstanding balance after insurance.
- For those who do not want insurance billed, there is a cash pay option that must be paid at the time of the service.

**Financial Consent:** I have read the Financial Policy. I understand and agree to this policy. I also understand that I will be responsible for services considered as non-covered. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to TriState Health.

## Consent For Receiving Influenza Vaccination

I have been given the opportunity to review/read the VIS which contains the information about influenza and influenza vaccine. I understand the risks of the vaccine and possible side effects as outlined in that information. I am aware that the vaccine should not be administered to anyone with a history of allergy to chicken eggs or to any component of influenza vaccine, including Thimerosal, (mercury derivative) without first contacting a physician. I attest that I have not had a history of Guillain-Barré syndrome. I deny any acute febrile illness today. I authorize the nurse to administer the influenza vaccine as described in the information I have read. I release the TriState Health of any responsibility for reactions or side effects I may experience.

___________________________________ ___________________________________ Date ____/____/_______

Print Name of Patient/Garantor Patient/Garantor Signature

## For Office Use Only

**LOT #** _________________________ **EXPIRATION DATE** ____/____/_______ **BRAND** _________________________

**SITE OF INJECTION** ❑ **R deltoid** ❑ **L deltoid** **GIVEN BY** ________________________________________