

## CONSENT TO ARRANGE FOR PAYMENT AND RELEASE INFORMATION

### Information about Individual to Receive Vaccine (Please Print)

|   |   |           |
|---|---|-----------|
| NAME (Last)   | (First)   | (M.I.)    |
| DATE OF BIRTH<br>Month _____ Day _____ Year _____   | <input type="checkbox"/> Male <input type="checkbox"/> Female | Age _____ |
| ADDRESS   | DAYTIME PHONE NUMBER  |           |
| CITY  | STATE   | ZIP       |
| <b>Payment Information</b>  |   |           |
| Primary Payer or Health Plan  | ID Number   |           |
|   | Group or Account Number                                       |           |
| Secondary Payer or Health Plan  | ID Number   |           |
|   | Group or Account Number                                       |           |
| <input type="checkbox"/> Cash Payment or <input type="checkbox"/> Check # _____ Amount: _____ |   |           |
| Receipt Given <input type="checkbox"/> Yes <input type="checkbox"/> No                        |   |           |
| <input type="checkbox"/> Company Paid   | Company Name: _____   |           |

We are required by law to ask you to sign this form. This form is important to your privacy rights.

#### ARRANGING PAYMENT

➤ **Assignment of Benefits and Responsibility for Payment:** *This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan.*

I authorize Homeland Health Specialists, Inc. to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to co payments, deductibles and co insurance.

#### RELEASING INFORMATION

➤ **For Care, Payment and Operations:** *This allows us to coordinate your care with other healthcare providers and to bill for our services. This also allows your health plan to process your claims and provide services to you.*

I authorize Homeland Health Specialists, Inc. to release information from my health records for treatment, payment and health care operations.

I authorize Homeland Health Specialists, Inc. to release information from my health records for purposes of processing and paying claims, coordinating benefits, coordinating care, payment and health care operations, including those functions that are required by my health plan or other third party payers.

I authorize Homeland Health Specialists, Inc. to release information from my health records to appropriate accreditation and quality review personnel such as your health plan or the Minnesota Department of Health.

#### SIGNATURE AND ACKNOWLEDGEMENT

I understand that I may revoke or cancel this consent in writing at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

### Screening for Influenza Vaccine

| Please mark YES or NO for each question.   | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you ill today?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a serious allergy to eggs or thimerosal?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction to a previous dose of vaccine?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had Guillain-Barré Syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>FLUMIST QUESTIONS ONLY</b>  |                          |                          |
| 5. Do you have any chronic health conditions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you on long-term aspirin or aspirin-containing therapy?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have close contact with a person who is hospitalized and in a protected environment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you or have you been on an antiviral medication within the last 48 hours?               | <input type="checkbox"/> | <input type="checkbox"/> |

#### For Administrative Use Only

|   |  |  |
|---|--|--|
| <b>Vaccine</b><br>Influenza<br><br><b>Dx Code</b><br>V04.81 | <b>FluMist</b><br><br><input type="checkbox"/> <b>MedImmune</b><br><br><b>Age 2-49 years ONLY</b><br><br><b>CPT 90660</b><br><br><b>Intranasal 0.2ml</b><br><br><b>Lot Number:</b> _____<br><br><b>Exp Date:</b> _____ | <b>Injection</b><br><br><b>Site:</b> <input type="checkbox"/> <b>Right Deltoid</b> <input type="checkbox"/> <b>Left Deltoid</b> <input type="checkbox"/> _____<br><br><b>Lot:</b> _____ <b>Exp Date:</b> _____<br><br><input type="checkbox"/> Multidose vial ages 18 and older 90658 - 0.5ml IM- Mfg: GSK<br><input type="checkbox"/> Multidose vial ages 3-17 years 90658- 0.5ml IM: Sanofi<br><input type="checkbox"/> Multidose vial ages 6 – 35 months 90657- 0.25ml IM: Sanofi<br><input type="checkbox"/> Individual High Dose ages 65 and older 90662- 0.5ml IM- Mfg: Sanofi<br><input type="checkbox"/> Individual dose Thimerosal free ages 6-35 months 90655- 0.25ml IM: Sanofi<br><input type="checkbox"/> Individual dose Thimerosal free ages 3 and older 90656- 0.5ml IM: GSK |
|---|--|--|

|  |                                     |
|--|-------------------------------------|
| <b>Date Vaccination &amp; VIS Given:</b> | <b>Vaccinator Name &amp; Title:</b> |
|--|-------------------------------------|

|  |   |
|--|---|
| <b>Verification of acceptable insurance or payment Senior or Medicare eligible</b><br><input type="checkbox"/> Medicare with a supplement<br><input type="checkbox"/> UCare only<br><input type="checkbox"/> Cash or Check<br><br><b>Work or Employer –patients under 65 years of age</b><br><input type="checkbox"/> BCBS of any state in the USA<br><input type="checkbox"/> HealthPartners not Cigna<br><input type="checkbox"/> Medica not United Health Care<br><input type="checkbox"/> Preferred One<br><input type="checkbox"/> America’s TPA or PPO<br><input type="checkbox"/> South Country Health Alliance<br><input type="checkbox"/> PrimeWest<br><input type="checkbox"/> UCare<br><input type="checkbox"/> Company Paid per Clinic Event Details<br><input type="checkbox"/> Cash or Check<br><br>Registrar Signature: _____ | <b>Medical Records</b><br><br><input type="checkbox"/> <b>Correct in Medical Record</b><br><br><input type="checkbox"/> <b>Corrections needed in Medical Record</b><br><br><input type="checkbox"/> <b>Correction made in Medical Record</b><br><br><input type="checkbox"/> <b>Medical Record not checked</b><br><br>Comments: |
|--|---|