Flu Vaccination Registration Form

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Sex: M:_____ F_____ Home Phone _____

Home Address: _____ City: _____ State _____ Zip: _____

PRIMARY HEALTH INSURANCE INFORMATION

Insured's Name _____Relationship to Insured:_____

Effective date_____ Group # _____Member # _____

I consent and authorize **HealthTexas Medical Group of San Antonio** to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner. I also understand that my prescription history from non-HTMG providers and pharmacies will be available to HTMG. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Texas Department of State Health Services

Addendum to Inactivated Influenza Vaccine
Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: [X] Inactivated Influenza Vaccine

***STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

Provider Identification Number: _____

Medicare Health Insurance Claim Number: _____

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

x _____ Witness Date _____

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer: SANOFI PASTEUR

Vaccine Lot Number: UI826AC

Site of Injection: _____ Deltoid

Signature of Vaccine Administrator:

Title of Vaccine Administrator: CMA

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Instructions: File this consent statement in the patient's chart.