



Riley County Health Department
 2030 Tecumseh Rd
 Manhattan, Kansas 66502
 Phone: 785-776-4779
 Fax: 785-565-6566
 www.rileycountyks.gov/health

2017-2018 Influenza Consent Form

DEMOGRAPHICS					
Patient's First Name:		Middle Name:		Last Name:	
Maiden Name/Alias:		Birth Date:		Age:	Phone Number:
Social Security Number:		Primary Language:			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Race:		Doctor:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Asian/Pacific Islander/Other		<input type="checkbox"/> Caucasian or White	
		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Hawaiian	
		<input type="checkbox"/> Native American/Alaska Native		<input type="checkbox"/> Unknown or Other	
Mailing Address:		Apt #:	City:	State:	County:
					Zip Code:

BILLING	
<input type="checkbox"/> Full Time Employee	<input type="checkbox"/> Part Time Employee
<p>Yes <input type="checkbox"/> No <input type="checkbox"/> immunizations are covered by my health insurance? If NO : read carefully - IN ORDER TO COMPLY WITH STATE REGULATION WE ARE UNABLE TO USE (VFC) INJECTIONS UNLESS WE HAVE A WRITTEN STATEMENT FROM YOUR INSURANCE COMPANY STATING IMMUNIZATIONS ARE NOT COVERED. IF WE DO NOT HAVE A WRITTEN STATEMENT PRIOR TO INJECTION THE PATIENT WILL BE RESPONSIBLE FOR ANY PORTION THAT INSURANCE WILL NOT COVER.</p>	

Primary Insurance Carrier
 Insurance Co. Name _____ ID#: _____ Group# _____
 Policy Holder (Name): _____ Policy Holder's Birthdate: _____
 Patient's relationship to policy holder (child, spouse, self) _____

Secondary Insurance Carrier
 Insurance Co. Name _____ ID#: _____ Group# _____
 Policy Holder (Name): _____ Policy Holder's Birthdate: _____
 Patients relationship to policy holder (child, spouse, self) _____

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance.

All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charges. If you fail to inform the Health Department of Insurance coverage in a timely manner. I have read the information above, understands the information and agree with my signature below. I also certify that the information provided on this page is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the RCHD Privacy Policy dated 9-2013.

SIGNATURE _____ **DATE** _____

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Are you sick or experiencing a high fever?	Yes No
2. Do you have allergies to medications, food, a vaccine component, or latex? List:	Yes No
3. Have you ever had a serious reaction after receiving a vaccination? Please explain:	Yes No
4. Have you ever had Guillain-Barré syndrome? (autoimmune disorder in which the immune system attacks nerve cells)	Yes No

VACCINE CONSENT	
<p>I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.</p>	
<input checked="" type="checkbox"/> Influenza	
X _____ Date: _____	
<i>Signature of Client or Parent/Guardian</i>	

PATIENT ELIGIBILITY (FOR CLINIC AND/OR OFFICE USE ONLY)				
Public	T19-MED	Manufacturer:	90662	FLU HIGH DOSE
Public	No Health Insurance ≤ 18	Lot Number:	90688	FLU-MDV
Public	Nat Am/AI Nat	Expiration Date:	90687	FLU-MDV-Infant
Public	Underinsured	INJECTION SITE:		90686P/T21/T19 FLU PF > 36 Mths
Public	T21-CHIP	Left / Right	Deltoid / Vastus Lateralus	90686P FLU PF > 36 Mths Public
Private	Fully Insured			90685 P/T21/T19 FLU PF 6-35 Mths
Private	No health insurance ≥ 19			90685P FLU PF 6-35 Mths Public
				90471 1 st Injection
	FREE FLU – NO CHARGE	VACCINE ADMINISTRATOR:	Date:	G0008 Medicare Flu Injection