Insurance Claim Form
Consent Influenza Immunization

GetA*FluShot*.com
A Professional Health Care, LLC Company,
Established 1989 Community Immunization
Provider since 1991

Insurance Plan: ☐ Regence Blue Cross ☐ Providence Health Plan ☐ Moda ☐ Premera ☐ Lifewise ☐ Kaiser ☐ Aetna
☐ Humana Medicare Advantage ☐ Medicare ☐ Pacific Source ☐ Uniform Medical Plan ☐ OR Medicaid Other _____
☐ First Choice Health ☐ United Health Care ☐ UMR Is your plan considered an HMO plan ☐ Yes ☐ No

Primary Insurance #

Secondary Insurance #

Last Name

First Name

Your Street Address where you receive your insurance paperwork

City ***State*** ***Zip Code***

Telephone (000-000-0000) ***Date of Birth(Month/Day/Year)***

Male ☐ ***Female*** ☐ ***Not Identified*** ☐

Email Address _____

Have you ever had a flu vaccination before? ☐Yes ☐No ☐Unsure
Have you ever had a severe reaction to a flu shot? ☐ Yes ☐ No
Do you have a history of Guillain-Barre Syndrome? ☐ Yes ☐ No
Are you feeling sick today? ☐ Yes ☐ No

Are you allergic to a component of the vaccine? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

I have read the adverse reactions associated with the influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. I have read the adverse reactions associated with the vaccine. A copy of the Vaccine Information Sheet s available on request. I have had the opportunity to ask questions about these immunizations and I have been offered a copy of the Vaccine Information Sheet for the vaccine being administered. I ask that the immunization be given to me or the person named below for whom I am authorized to make this request. For myself, my heirs, executors, personal representatives and assigns, I hereby release all counties, GetaFluShot (GAFS), corporation, school, school district, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). GAFS and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. I agree that I am responsible for reimbursing GAFS for the cost of the vaccine and administration, using CMS guidelines, if I do not have active insurance or insurance accepted by GAFS on the date of immunization. I also agree that GAFS may contact me if more information is required to process my consent form for reimbursement.

Signature of responsible person ***Relationship to Insured*** ☐ Self ☐ Spouse ☐ Child ***Date Signed***

Clinic Name _____

Date of Vaccination: _____ VIS 8/6/2021

Mfg/Lot #: _____ **Expiration Date:** _____

Nurse's Initials: _____ **Site of Injection: L R Deltoid**

NURSE NOTES