Insurance Claim Form and Consent
Covid Immunization

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

If you have experienced severe reaction, allergies to vaccines or carry an Epi Pen, you will need to obtain your Covid vaccine at a medical facility for your safety

Insurance Plan: ☐ Regence Blue Cross ☐ Providence Health Plan ☐ Moda ☐ Premera ☐ Lifewise ☐ Kaiser ☐ Aetna ☐ Medicare

☐ Humana Medicare Advantage ☐ Pacific Source ☐ Uniform Medical Plan ☐ OR Medicaid ☐ United Health Care ☐ UMR _____ *Other Insurance*

Primary Insurance # (not Group)

Seconday Insurance # (not Group)

Last Name

Email Address

First Name

Your Street Address where you receive your insurance paperwork (not your email address)

City ***State*** ***ZIP Code***

Telephone (000-000-0000) ***Date of Birth (MM-DD-YYYY)*** ***Gender***

☐ *Male* ☐ *Non Binary* ☐ *Female* ☐ *Other*

Do you have a fever?	Yes ☐	**No** ☐	If female, are you pregnant or plan to become pregnant	Yes ☐	**No** ☐
Do you have any allergies?	Yes ☐	No ☐	If female, are you breastfeeding	Yes ☐	**No** ☐
Do you have a bleeding disorder or on blood thinners	Yes ☐	No ☐	Have you had a severe reaction after a previous dose of Covid Vaccine or to any ingredients in the vaccine	Yes ☐	**No** ☐
Are you immunocompromised or on a medicine that affects your immune system	Yes ☐	No ☐			
Have you received another dose of Covid Vaccine	Yes ☐		*Date of Last Dose (mm-dd-yyyy)* – –		No ☐

I have read the adverse reactions associated with the Covid vaccine. A copy of the Covid-19 Vaccine Information Sheet (VIS) is available on request. I have had the opportunity to ask questions about these immunizations and I have been offered a copy of the Covid-19 VIS for the vaccine(s) being administered. I ask that the immunization(s) 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 (MM-DD-YYYY)

Clinic Name_____

Date of Vaccination: _____

Mfg/Lot #: _____ Expiration Date: _____

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

NURSE NOTES