Circle One
6WXGHQW ,PSOR\H

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive 1R VHYHUH DOOHUJLF UHDFWLRQ WR IOX YDFFLQH LQ WKH SDVW 1R

ODWH[DOOHUJ\ 1R KLVWRU\ RI *XLOODLQ %DUUH 6\QGURPH

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for service provided by them.

ACKNOWLEDGEMENT

KDYH UHDG DQG EHHQ RIIHUHG D FRS\ RI WKH 9DFFLQH ,QIRUPDWLRQ 6WDWHPHQW SULRU WR P\ YDFFLQDWLRQ

DQG KDYH EHHQ JLYHQ DQ RSSRUWXQLW\ WR DVN TXHVWLRQV DERXW WKH EHQHILWV DQG ULVNV RI WKH YDFFLQDWLRQ

$//,1)250$7,21 %(/2: 725(&(,9(,1)/8(1=$ 9$&&,1(

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

First Name **MI** **Last Name**

Address Number **Street Name** **Gender M/F/Other**

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

Age **Date of Birth** **Area Code** **Phone Number**

Email (optional)

Race: :KLWH $IULFDQ $PHULFDQ %ODFN 3DFLILF ,VODQGHU 7ZR RU 0RUH

Ethnicity: +LVSDQLF 1RQ-+LVSDQLF /DWLQR

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

Aetna **Anthem/Blue Cross Blue Shield** **Cigna** **Humana** **HealthLink** **WellFirst (SSM)**

UHC **UMR** **All Savers** **GEHA** **Golden Rule** **TriCare________** **Medica**

Medicare Plans: **Medicare Part B** **Anthem/Blue Cross Blue Shield** **Essence**

Medicare Advantage Plan: **Aetna PPO** **Cigna PPO** **Coventry PPO** **HealthLink PPO** **Humana PPO** **UHC PPO**

Subscribers Name:________________ **Subscribers D.O.B. ____/____/____** **Relationship to subscriber:________________**

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

BBBBBBB BBBBBBBB BBBBBBB ________________________________ /________

'DWH 6LJQDWXUH 3DUHQW RU /HJDO *XDUGLDQ 5HODWLRQVKLS

INSURANCE MBR ID

Cash **Check # ________________** **Bill**

Clinic ID#	X B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B Nurse Signature Date Given	0.5 ml Lot Given A B C D E F G	IM Site Given Deltoid” Thigh L ŏ R

”5HYLVHG6$,17/28,681,9(56,7<9(56,21