REGULAR

TEXAS Department of State Health Services

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: ☐ 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 _____ Date _____
Witness

For Clinic/Office Use
Clinic/Office Address: 925 E Southlake Blvd #-100 Southlake, TX 76092
Date Vaccine Administered:
Vaccine Manufacturer: GSK
Vaccine Lot Number: FK43S
Site of Injection:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

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.

Name:_____ Date of Birth:_____

(PLEASE PRINT)

FOR OFFICE USE ONLY

☐ FILE INSURANCE MRN# _____

☐ ESTABLISHED PT (SELF PAY) MRN# _____

☐ SELF PAY MRN# 9344455

CODES FOR FLU SHOT:

********All vaccines are preservative free********

_____ 90686P FLU SHOT (6 MONTHS AND OVER) $50.00

_____ 90662MC HIGH DOSE FLU SHOT (MEDICARE 65 +) $77.00

_____ **90662P HIGH DOSE FLU SHOT (COMMERCIAL)** **$77.00 ****

Southlake Family Medicine
Insurance Waiver

Patient Name_____ **Acct#**_____

Provider Statement
Based on the information that you have provided to us, we believe that it is likely that your insurance company _____will limit or deny coverage for the following services due to age requirement:

High Dose Flu Vaccine $ 77.00

BENEFICIARY'S STATEMENT:

_____Yes. I want to receive these items or services. I understand that my insurance company may not/will not pay. I understand that I am personally and fully responsible for the payment.

_____ _____
Beneficiary Signature Date

Southlake Family Medicine
925 E. Southlake Blvd., Suite 100
Southlake, Texas 76092
**TAX ID # 752536818