

****HIGH DOSE****



**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)					For Clinic/Office Use	
Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one)		925 E Southlake Blvd # 100 Southlake, TX 76092
				M	F	Date Vaccine Administered:
Address: Street	City	County	State	Zip		Vaccine Manufacturer: Sanofi
			TX			Vaccine Lot Number: UI981AB
Signature of person to receive vaccine or person authorized to make the request (parent or guardian):					Site of Injection:	
X _____ Date _____					Signature of Vaccine Administrator:	
X _____ Date _____					Title of Vaccine Administrator:	
Witness						

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.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

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