Healthwaves444™
1615 W. University Dr., Suite 137, Tempe AZ 85281 • 480-968-1886

2016–2017

FLU AND PNEUMONIA IMMUNIZATION CONSENT

SIGNATURE AND CONSENT

I have read or have had explained to me the information about the influenza (flu) vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand that I should not receive the vaccine if I: **(1) have ever had a serious allergic reaction to eggs or to the vaccine; (2) have a fever, acute respiratory or other active infection or illness; (3) have a history of Guillain-Barre Syndrome (a severe, paralytic illness)**.

The 2016–2017 Quadrivalent vaccine virus strains are: an A/California/7/2009 (H1N1)pdm09-like virus, an A/Hong Kong/4801/2014 (H3N2)-like virus, a B/Brisbane/60/2008-like virus (B/Victoria lineage) and a B/Phuket/3073/2013-like virus (B/Yamagata lineage virus). (High doze flu zone vaccine contains **only** the first three strains listed.)

The flu vaccine cannot cause the flu because it uses dead viruses. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals. Most people have no side effects from receiving the flu shot. Serious side effects, such as severe allergic reactions, have rarely been reported for the flu vaccine. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request. Healthwaves practices in accordance with the HIPAA regulations as pertains to privacy practices and patient confidentiality regarding protected health information.

UPDATED 08/2016

TODAY'S DATE: ___/___/___

INFORMATION ON PERSON TO RECEIVE VACCINE (PLEASE PRINT)
ALL BOXES **MUST** BE FILLED OUT

LAST NAME	FIRST NAME	BIRTH DATE **MM/DD/YY**	AGE	SEX (M/F)
		/ /		

MAILING ADDRESS	APT #

CITY	STATE	ZIP	PHONE NUMBER
		_ _ _ _ _ - _ _ _ _	

PRIMARY CARD HOLDER

LAST NAME	FIRST NAME	BIRTH DATE **MM/DD/YY**	SEX (M/F)
		/ /	

ACCEPTED INSURANCE PLANS-VALID & CURRENT INSURANCE CARD MUST BE SHOWN
You are responsible for payment in full if insurance coverage is denied. (Including co–pays and co–insurance)

X _____
SIGNATURE

☐ **BCBSAZ**
Medicare Advantage Plans NOT included.

ALPHA PREFIX: ☐☐☐ MEMBER ID# ☐☐☐☐☐☐☐☐☐ GROUP #: ☐

☐ **BCBS-FEP**
Medicare Advantage Plans NOT included.

MEMBER ID#: R ☐☐☐☐☐☐☐☐ ENROLLMENT CODE: ☐☐☐

☐ **BLUE PLANS (OUT–OF–STATE)**
Customer Service Phone Number: _____

ISSUING STATE: ☐ MEMBER ID # (INCLUDING ANY LETTERS): ☐ GROUP #: ☐

☐ **OTHER BCBS NETWORK PLANS**
Customer Service Phone Number: _____

MEMBER ID # ☐ GROUP #: ☐ **MEDICAL GROUP #:** ☐

☐ **MEDICARE PART B** Medicare is my **PRIMARY MEDICAL COVERAGE**, or I will be responsible for charges. I request that payment of authorized medicare benefits be made on my behalf to Healthwaves (Patrick N. Connell, M.D.) provider # MD 9047 for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HFCA) and its agents any information needed to determine these benefits or the benefits payable for related services.
NOTE: Medicare will generally only pay for one pneumonia shot.

MEDICARE B CLAIM #: ☐☐☐ – ☐☐ – ☐☐☐☐ LETTER: ☐☐

ADDRESS ON MEDICARE FILE:

INITIALS

Please be aware of Medicare fraud. I am responsible for payment if medicare is not my primary insurance provider.

☐ **HUMANA GOLD CHOICE**

HUMANA GOLD CHOICE MEMBER ID# INCLUDING ANY LETTERS: ☐☐☐☐☐☐☐☐☐

HEALTHWAVES PERSONNEL ONLY

☐ **QUADRIVALENT FLU $40** CPT CODE: 90688 CDC Info. Sheet 08/07/15	☐ **PN** (Pneumonia) **$105** CPT CODE: 90732 CDC Info. Sheet 04/24/15	☐ **HIGH DOSE $55** CPT CODE: 90662 ☐ **PRESERVATIVE FREE $50** CPT CODE: 90686	AMOUNT PAID $ ☐ CASH ☐ CHECK & CHECK # _____ ☐ CREDIT CARD	NOTES:
FLU SHOT: RN INITIALS / ARM	PNEUMONIA SHOT: RN INITIALS / ARM	RN INITIALS / ARM	CHECKED INS. CARD? ☐ YES ☐ NO ☐ Medicare ☐ BCBS AZ ☐ Humana Gold Choice	LOCATION / INITIALS