



INFLUENZA VACCINATION REGISTRATION INFORMATION

Patient Information

Date of Service ____/____/____

Patient Name _____ Sex _____ Age _____ Date of Birth ____/____/____

Mailing Address _____ City _____ State _____ Zip _____

Phone # _____ Phone Type _____ Email _____

Primary Care Provider _____

Guarantor Info

Guarantor Name _____ Relation to Patient _____

Date of Birth ____/____/____ Phone # _____ Phone Type _____

Insurance Card Copied Yes No

Financial Policy

- Charges will be billed to the responsible patient/guarantor's insurance company only if you provide current and accurate insurance card at the time services are rendered.
- Guarantor will be responsible for any unpaid balance, if applicable, and must pay upon receipt of Explanation of Benefits (EOB) or upon receipt of invoice from Tri-State Memorial Hospital & Medical Campus.
- We accept cash, check, and credit/debit card for any outstanding balance after insurance.
- For those who do not want insurance billed, there is a cash pay option that must be paid at the time of the service.

Financial Consent: I have read the Financial Policy. I understand and agree to this policy. I also understand that I will be responsible for services considered as non-covered. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to Tri-State Memorial Hospital.

Consent For Receiving Influenza Vaccination

I have been given the opportunity to review/read the VIS which contains the information about influenza and influenza vaccine. I understand the risks of the vaccine and possible side effects as outlined in that information. I am aware that the vaccine should not be administered to anyone with a history of allergy to chicken eggs or to any component of influenza vaccine, including Thimerosal, (mercury derivative) without first contacting a physician. I attest that I have not had a history of Guillain-Barré syndrome. I deny any acute febrile illness today. I authorize the nurse to administer the influenza vaccine as described in the information I have read. I release the TSMH hospital of any responsibility for reactions or side effects I may experience.

Print Name of Patient/Guarantor

Patient/Guarantor Signature

Date ____/____/____

For Office Use Only

LOT # _____ EXPIRATION DATE ____/____/____ BRAND _____

SITE OF INJECTION R deltoid L deltoid GIVEN BY _____