



A Professional Health Care LLC Company, Established 1989
Community Immunization Provider since 1991

City of Seattle Consent & Claim Form: Influenza Immunization

Check primary insurance plan: Group Health Aetna Preventive Aetna Traditional (Local 77 only)
Aetna SPOG and Most Traditional plans not accepted for vaccinations Medicare Part B _____

For use by City of Seattle and King County employees only

Last Name: _____ First Name: _____ (middle initial) MI: _____

Primary Insurance ID #																				
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(Secondary Insurance) Insurance Plan: _____ ID Number: _____

(Month/Day/Year) Date of Birth: _____ Sex: F M

Mailing Address: _____

City: _____ State: WA ZIP Code: _____

Phone #: (_____) _____ - _____

Have you ever had a flu vaccination before? Yes No Unsure Are you allergic to eggs? Yes No

Have you ever had a severe reaction to a flu shot? Yes No Are you allergic to latex? Yes No

Do you have a history of Guillain-Barre Syndrome? Yes No If female, are you pregnant? Yes No

I have read/had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions and had them answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither GetAFluShot.com nor its sponsor or host site shall have any responsibility or liability if I contract influenza or other respiratory diseases, or suffer any other adverse reaction, following administration of the flu shot. I understand that I am responsible for payment for the vaccine if my insurance carrier denies payment.

X Signature of responsible person: _____ Relationship: _____ Date: _____

Community Provider/Health Plan Use Only

Federal Tax ID: 91-1754065 Service Location: 60
Practice NPI # 1528244282
Rendering Provider NPI# 1558496158
CPT Code (Inj. vaccine): 90658 CPT Code (admin): 90471

Diagnosis Code: V04.81

Clinic Use Only

Clinic Location: _____
Date of Vaccination: _____
Mfg/Lot #: _____ Expiration Date: _____
Nurse's Initials: _____ Site of Injection: L R Deltoid