CONSENT FOR SERVICES FORM

Every section of this form is required.

Patient Information

Last Name	First Name, Middle Initial	Suffix	Birth Date (month/date/year)	Age	Sex

Complete Mailing Address	City	State	Zip

Birth Date (month/date/year)	Age	Sex	Demographic Information (circle one)
			American Indian/Native Alaskan Black Asian Hispanic White Other

Parent/Guardian Information (if applicable)

Last Name	First Name, Middle Initial	Suffix	Email Address
			Primary Phone Number

Required Health Insurance Information

Check one:

- ☐ Private Insurance
- ☐ Medicaid (ex: Healthy Indiana Plan, Hoosier Care Connect, Hoosier Healthwise)
- ☐ No Insurance: I certify that the patient is not covered by any health insurance.

Check One:

- ☐ The patient currently has insurance and I wish for today's service to be billed through my insurance policy. I will provide the correct insurance information.
- ☐ The patient currently has insurance but I DO NOT want today's services to be billed through my policy. I will pay for today's services with cash or credit/debit card.
- ☐ The patient is currently uninsured and I will pay for today's services with cash or credit/debit card.

Insurance Company	Member ID

Policy Holder's Name	Policy Holder's Date of Birth	Patient's Primary Care Provider

Demographic Information

Number of people in my household: _____

My current household income is: ☐ below $11,800 ☐ $11,881 - $24,300 ☐ $24,301 - $ 36,450 ☐ $36,451 - $48,600 ☐ $48,601 - $60,750 ☐ $60,751 - $72,900 ☐ over $72,901

Medical Information **Please circle Yes or No for <u>all</u> questions. Answers are for the person getting the vaccine.**

1.	Is the patient sick today?	Yes	No
2.	Has the patient had a fever in the last 24 hours?	Yes	No
3.	Is the patient allergic to any vaccine components such as eggs, gentamicin, arginine, gelatin, or MSG?	Yes	No
4.	Does the patient have any of the following: (mark all that apply) ☐ Chronic heart disease(s) ☐ Diabetes/metabolic disease/disorder ☐ Blood disease(s) ☐ Kidney disease/disorder(s) ☐ Liver disorders ☐ An inhaler that is used regularly ☐ Asthma/reactive airway disease/wheezing ☐ Weakened immune system, cancer, lupus, or HIV/AIDS ☐ A medication that lowers the body's resistance to infection		
5.	Has the patient had chickenpox disease?	Yes	No
6.	Is the patient on long-term aspirin therapy or taking Tamiflu®, Relenza®, amantadine, or rimantadine?	Yes	No
7.	Does the patient have close contact with severely immunocompromised persons who require a protective environment?	Yes	No
8.	Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes	No
9.	Does the patient now have or had any history of Guillian-Barre Syndrome (GBS)?	Yes	No

All information I have provided on the consent for vaccination is true and correct. I have received the HIPAA Notice of Privacy Policy. I have received, read, and understand the CDC Vaccine Information Statements for the vaccines the patient will receive today. I give permission to Super Shot to communicate with other healthcare providers, as needed, and for data entry, billing, and storage according to Indiana Department of Health Policies and if applicable, to give my child the vaccine in my absence. By signing below I agree to the payment option for today's services that I have selected. I understand that if I have asked for a claim to be filed to my insurance company, I am responsible for charges not covered by my insurance plan and agree to pay them in full.

Printed Name of Patient or Parent/Guardian _____ Signature of Patient or Parent/Guardian _____ Date _____

For Official Use Only | Reviewed by: _____ Date: _____ | Signature of Administrator/VIS provided: _____ Date: _____

Vaccine	Manufacture & Lot #	Route/Site	Date of VIS	Vaccine	Manufacture & Lot #	Route/Site	Date of VIS	Vaccine	Manufacture & Lot #	Route/Site	Date of VIS
Dtap / P / K			8.24.18	IPV / P / K			10.30.19	PCV 23			10.30.19
Hep A			7.20.16	MMR / Q			8.15.19	Tdap			2.24.15
Hep B / P			8.15.19	MCV4			8.15.19	Varicella / Q			8.15.19
Hib			10.30.19	Men-B			8.15.19	Flu		IM/	
HPV-9			10.30.19	PCV 13			10.30.19				