Circle One
6WXGHQW)DFXOW\ (PSOR\H

MEDICAL HISTORY ACKNOWLEDGEMENT

Not Pregnant or currently trying to conceive. 1RVHYHUHDOOHUJLFUHDFWLRQVXFW7VKLIRUPHUYDOOHUJLHVRQRQ
ODWH[RHVQRWKDYHHVDEXQGDQFHUVRUIHYHU 1RKLVWRU\RI*XLOODLQ%DUUH6\QGURPH

[redacted]

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for services provided by them.

ACKNOWLEDGEMENT

KDYHUHDGDQGEHHQRIIHUHGDFRS\RIWKHYDFFLQHLQIRUPDWLRQVWDWHPHQW SULRUWRP\YDFFLQDWLRQ
DWWKHULVNVDQGEHQHILWVRIWKHYDFFLQH,KDYHKDGDFKDQFHWRDVNTXHVWLRQVWKDW,XQGHUVWDQG
YDFFLQDWLRQRQVXUHLWHWKHDWWHQWLRQRIDFOLQLFLDQ,H[SHFWWKHYDFFLQHHIIHFWV
P\SK\VLFLDQDWP\H[SHQVHLIQHHGHG UHGQHVVDQGRUVLWLVDW
LQFOXGHGLQDQ\FDVH IHYHUWKDWRFFXUVDIWHUYDFFLQDWLRQ
DQDSK\ODFWLFUHDFWLRQ
DIILOLDWHV
RXWRI

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RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

First Name **MI** **Last Name**

Address Number **Street Name** **Gender M/F/Other**

City **State** **Zip Code**

Age **Date of Birth** **Area Code** **Phone Number**

Email (optional)

Race: :KLWH $IULFDQ$PHULFDQ %ODFN $VLDQ +DZDLLDQ3DFLILF,VODQGHU 7ZRRU0RUH
Ethnicity: +LVSDQLF 1RQ+LVSDQLF /DWLQR

PLEASE PROVIDE INSURANCE INFORMATION BELOW:
Aetna **Anthem/Blue Cross Blue Shield** **Cigna** **Humana** **HealthLink** **WellFirst (SSM)**
UHC **UMR** **AllSavers** **GEHA** **Golden Rule** **TriCare________** **Medica**

Medicare Plans: **Medicare Part B** **Anthem/Blue Cross Blue Shield** **Essence**

Medicare Advantage Plan: **Aetna PPO** **Cigna PPO** **Coventry PPO** **HealthLink PPO** **Humana PPO** **UHC PPO**

Subscribers Name:_______________________ Subscribers D.O.B. ____/____/____ Relationship to subscriber:_______________

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

BBBBBBB BBBBBXBB BBBBBBB ____ /____________
'DWH 6LJQDWXUHRI3HUVRQ5HFHLYLQJ9DFFLQH 5HODWLRQVKLS

INSURANCE MBR ID

Cash **Check # _______________** **Bill**

Clinic ID#	X BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB Nurse Signature Date Given	0.5 ml Lot Given A B C D E F G	IM Site Given Deltoid" Thigh L ǒ R