The Austin Diagnostic Clinic
Influenza Vaccine Consent Form

Acct #:_____

Patient's Name (Last) _____ (First) _____ (MI) _____

Date of Birth _____ Sex_____

Address Line _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____Work Phone _____

Insurance _____ Self Pay ☐

- Financial communications:
  - I acknowledge that, as a courtesy, AUSTIN DIAGNOSTIC CLINIC may bill my insurance company for services provided to me.
  - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
  - I understand that there is a fee for returned checks.
  - Assignment of Benefits. I hereby assign to AUSTIN DIAGNOSTIC CLINIC any insurance or other third-party benefits available for health care services provided to me. I understand AUSTIN DIAGNOSTIC CLINIC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AUSTIN DIAGNOSTIC CLINIC, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.
  - Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to AUSTIN DIAGNOSTIC CLINIC by the Medicare or Medicaid program.
- Privacy Policies
  - I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.
  - I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.
    - Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
    - If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
    - Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient's Name (Last) _____ (First) _____ (MI) _____Date of Birth _____

Temperature: _____ (100.4 F or greater should not receive vaccine today)

PLEASE CIRCLE AN ANSWER TO THE QUESTIONS BELOW:

Is the person to be vaccinated sick today?	Yes ☐	No ☐
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	Yes ☐	No ☐
Has the person to be vaccinated ever had a reaction to influenza vaccine in the past?	Yes ☐	No ☐
Has the person to be vaccinated ever had Guillain-Barre syndrome?	Yes ☐	No ☐
Were you offered or given an Information Statement (VIS) about this vaccine? VIS: Inactivated Influenza Vaccine (08/06/2021) 42 U.S.C. § 300aa-26	Yes ☐	No ☐

I have read, or have had explained to me, information about the disease and the vaccine listed above, the financial and privacy information listed above. I understand the benefits and risks of the vaccine cited and consent that the vaccine be given to me or the person named above for whom I am authorized to make this request.

_____ _____

Signature of patient or guardian *Date*

TO BE COMPLETED BY ADC STAFF

	INJECTION	DOSE	Vaccine CPT code	Administration Code		DESCRIPTION	ICD 10 CODE
ADULT	Influenza (Adult)	**0.5ml**	**90686**	**90471**		**Fluarix Quadrivalent Vaccine**	**Z23**
	Influenza (Adult) **Egg-Free**	**0.5ml**	**90674**	**90471**		**Flucelvax Quadrivalent Vaccine**	**Z23**
	Influenza (Adult) **High Dose**	**0.5ml**	**90694**	**90471**		**Fluad High Dose Quadrivalent Vaccine**	**Z23**
PEDIATRICS (Private Ins.)	**INJECTION**	**DOSE**	**Vaccine CPT code**	**Admin Code for up to 18 YO**	**Admin with Counseling up to 18 YO**	**DESCRIPTION**	**CODE**
	6 mo. -18 yrs.	**0.5ml**	**90686**	**90471**	**90460**	**Fluarix Quadrivalent Vaccine**	**Z23**
PEDI VFC	6 mo. -18 yrs.	**0.5ml**	**90686**	**90471**	**90460**	**Fluarix/Fluzone Quadrivalent Vaccine (VFC Stock)**	**Z23**
PEDI VFC	6 mo. -18 yrs.	**0.25ml**	**90686**	**90471**	**90460**	**Fluzone Quadrivalent Vaccine (VFC Stock) – *First Flu Shot 6mo-35mo.***	**Z23**
SHOTS FOR TOTS	6 mo. - 18 yrs.			**90471- $14.85**		**Any flu vaccine under shots for tots program. (Do not bill separate vaccine CPT code)**	**Z23**

Brand (Circle one): ☐ **GSK** ☐ **Sanofi** ☐ **Seqirus** **Lot #:** _____

Site: ☐ ☐ **Deltoid/Thigh** ☐ ☐ **R or L**

Administered by: _____ **Date:** _____

REV. 08/02/2022