FLU SHOT QUESTIONNAIRE

Name: ______________________________ Date of Birth: ______/______/______

Address: ______________________________ Home Number: ______________________

______________________________ Cell Phone: ______________________

Primary Insurance Plan: ______________________ Policy Holder: ______________________

Member ID: ______________________ Group #: ______________________

How did you hear about us? ____

CONTRAINDICATIONS TO THE FLU SHOT

	YES	NO
1. Are you in the first trimester of pregnancy?	_____	_____
2. Are you ill or have fever?	_____	_____
3. Have you ever had a reaction to the flu vaccine?	_____	_____
4. Have you ever had Guillian Barre Syndrome?	_____	_____

There is a possible chance you may not receive the flu shot if you answered "YES" to one of the following questions above.

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of The Urgent Care's full Notice of Privacy Practices are available on request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand The Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund. Credit balances remaining will be handled per the Patient Responsibility and Financial Policy may be assessed inactivity fees and/or processing fees if sent to the Louisiana Secretary of State LSA R.S. 9:151 et seq.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at The Urgent Care versus the hospital Emergency Department, my primary care, or a specialist. I authorize The Urgent Care to provide medical treatment and services to me. I understand I am authorizing The Urgent Care to treat me while I seek care from The Urgent Care or until I withdraw my authorization in writing.

Patient Signature: ______________________________________ Today's Date: _____/_____/_______

OFFICE USE ONLY:

Lot #: ______________________ Exp. Date: ______________________ Temp: ______________________

Given By: ______________________ Time: ______________________ Deltoid: ______________________

ICD 10: Z23 – Encounter for Immunization

FluZone Quad	**FluZone Quad MCR**	**FluZone High Dose MCR**	**FluBlok Quad**
90686 90471	Q2038 G0008	90662 G0008	90682 & 90471

THE
URGENT CARE
WALK-IN CLINIC