FLU - CLIENT CONSENT / REGISTRATION FORM

2550 N. ANNIE GLIDDEN ROAD
DEKALB, IL 60115
(815) 758-6673
PROVIDER # 36-6006548
NPI # 1548315344
Appointment Date: ______/______/______ Time:_____________

Peds Only:
☐ VFC
☐ PRIVATE
☐ CHIP

SECTION A: CLIENT INFORMATION (PLEASE PRINT)

LAST NAME ______________________________ FIRST NAME ______________________________ MI ________

DATE OF BIRTH ____/____/_______ AGE ______ ☐ MALE ☐ FEMALE PHONE # (________) ______________________________

ADDRESS ______________________________ CITY ______________________ STATE ______ ZIP ______________

COUNTY ______________________________ EMAIL ADDRESS ______________________________

PARENT/GUARDIAN'S LAST NAME:__________________________ FIRST NAME:____________________DOB:_____/_____/_____

SECTION B: STATE OF ILLINOIS EMPLOYEE

LAST 4 DIGITS OF SOCIAL SECURITY # ______ ______ ______ ______ **IF CLIENT HAS STATE OF ILLINOIS INSURANCE, SKIP SECTIONS C & D**

SECTION C: PRIVATE INSURANCE / MEDICARE ADVANTAGE / MEDICAID

PRIVATE INSURANCE/MEDICARE ADVANTAGE COMPANY ____

POLICY# ______________________________ GROUP # ______________________________ VFC: ☐ No ins. ☐ INS DNC ☐ AI/AN

MCO:__________________________ MEDICAID # ____ ____ ____ ____ ____ ____ ____ ____ ____ ☐ CHIP

CLIENT'S RELATIONSHIP TO POLICY HOLDER ☐ SELF **(If SELF, stop here)** ☐ CHILD ☐ SPOUSE ☐ OTHER__________________________

POLICY HOLDER'S NAME ______________________________ POLICY HOLDER'S DATE OF BIRTH ____/____/______

POLICY HOLDER'S ADDRESS ______________________________ CITY __________________________, IL ZIP ______________

SECTION D: MEDICARE PART B

MEDICARE # ____

SECTION E: ASSIGNMENT OF BENEFITS

VACCINE CLIENT: I have been given the Vaccine Information Sheet(s) (VIS) about the vaccine(s) that will be administered. I have read or have had explained to me the information about the vaccine(s). I have had an opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine(s) and ask that the vaccine(s) checked below be given to me or to the person above for whom I am authorized to make this request. In the event a blood or body fluid exposure occurs, I understand the DeKalb County Health Department (DCHD) staff may need to obtain a blood sample from the person mentioned above.

I consent to my name, address, phone number, appointments, and immunization record to be maintained in, I-CARE, Electronic Medical Records, and other computer billing systems. I also authorize release of this record to my physician for compliance purposes. I also hereby acknowledge that a copy of the Notice of Privacy Practices from DCHD dated April 14, 2003 was made available. I authorize the DCHD to release service-related information regarding the above mentioned client to third party payers. I understand that the insurance company benefits will be made payable to the DeKalb County Health Department. The client, parent, or legal representative is responsible for any services not covered by insurance plans. Co-payments will be made at the time of service. My signature below also indicates that all information provided on this form is true and accurate. Signature of person authorized to make the request: ☐ He Leido y entiendo la version de esta hoya en español.

______________________________ ______________________________ ____/____/_____
PRINT NAME **SIGNATURE** **MM/DD/YYYY**

OFFICE USE ONLY

VACCINE	SITE (CIRCLE)	√	ICD-10	CPT	FEE	ADMINISTRATION	√	CPT
Influenza -**Afluria** Seqiris	LAT / RAT / LLT / LD / RD		Z23	90686	$38	PPO		90471
Influenza-**Fluarix** GSK	LAT / RAT / LLT / LD / RD		Z23	90686	$38	Illinois Public Aid/MCO		99211
						Medicare/Medicare Advantage		G0008

Attach copy of ID & INS Card front and back

VIS DATE: 8/06/21

Place sticker in gray box Manufacturer

ROSTER BILL (NO CHARGE)
☐ State of IL Employee, or Survivor, on State of IL Health Insurance
☐ State of IL Retiree (not on Medicare) on State of IL Health Insurance
☐ *Health Department/Spouse/Dependent on County Insurance
☐ *DeKalb County Employee/Dependent/Retiree on County Insurance
☐ * Board Members
* (if other than client) Employee Name: ______________________________ DEPT:________________________

CHARGE CLIENT OR OBTAIN INSURANCE INFORMATION FOR BILLING
☐ $19 Health Department Dependent/Retiree not on County Insurance
☐ $38 DeKalb County Dependent/Retiree not on County Insurance
☐ $38 State of IL Employee not on (opt out) State of IL Health Insurance
☐ $38 State of IL Dependent
☐ $38 NIU Students

SIGNATURE OF RN ______________________________ **DATE** _____/_____/_________

I-CARE initials ________**DATE** ______ **Medi/MCO Checked Initials** _______ **DATE** ________ **DCHD INVOICE**____________________

AMOUNT PAID ____________ ☐ **CASH** ☐ **CHECK #** __________ ☐ **CREDIT CARD #** ___________