NIU FLU - CLIENT CONSENT/REGISTRATION FORM

DeKalb County Health Department
Prevent • Protect • Promote

OFFICE USE ONLY: √ the one that applies

18 yrs & under	19 yrs & over
❒ VFC	❒ PRIVATE
❒ PRIVATE	

Initials at √-IN _____

2550 N. ANNIE GLIDDEN ROAD DEKALB, IL 60115 (815) 758-6673 **PROVIDER # 36-6006548** **NPI # 1548315344**

SECTION A: CLIENT INFORMATION (PLEASE PRINT)

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____/_____/_____ AGE _____ ☐ MALE ☐ FEMALE PHONE # (_____) _____

ADDRESS _____ CITY _____ IL ZIP _____

COUNTY _____ EMAIL ADDRESS _____

SECTION B: Only for STATE OF ILLINOIS EMPLOYEES & RETIREES ON STATE OF IL HEALTH INSURANCE /RETIREES & SURVIVORS ON TRAIL MEDICARE ADVANTAGE-ROSTER

LAST 4 DIGITS OF SOCIAL SECURITY # _____ _____ _____ _____ **IF CLIENT MEETS CRITERIA, SKIP SECTIONS C & D**

SECTION C: PRIVATE INSURANCE / MEDICARE ADVANTAGE / MEDICAID/MEDICAID with TPL/SELF PAY ATTACH COPY OF ID & INS CARD (Front & Back)

PRIVATE INSURANCE/MEDICARE ADVANTAGE (COMPANY NAME)/ BCCHP:_____

POLICY# _____ GROUP # _____

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 _____

❒*IL MEDI IPA RECIPIENT#* ___ ___ ___ ___ ___ ___ ___ ___ ___ *MCO:* _____ ❒*TPL* ***18& ↓***: ❒SELF PAY- NON VFC ❒SELF PAY-VFC:NO INS; INS DNC; AI/AN ***19&↑***: ❒SELF PAY

AMOUNT PAID: _____ ❒ CASH ❒ CREDIT CARD

DCHD TO INVOICE: _____ BILLING ENTERED INTO COMPUTER - INITIALS : _____

SECTION D: MEDICARE PART B ATTACH COPY OF ID & MEDICARE CARD

MEDICARE # _____

SECTION E: ASSIGNMENT OF BENEFITS

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 be given to me or to the person mentioned 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 myself or the above mentioned person.

I consent to my name or the above mentioned person's name, address, phone number, appointments, and immunization record be maintained in, I-CARE, Electronic Medical Records, and other computer billing systems. I also authorize release of this record to my or the above mentioned person physician, daycares, preschools or school district 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 DCHD to release service-related information regarding the above mentioned person to third party payers. I understand that the insurance company benefits will be made payable to DCHD. 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 (client, parent or legal representative): ☐ He leido y entiendo la version de esta hoya en español.

_____ _____ _____/_____/_____

PRINT NAME **SIGNATURE** **MM DD YYYY**

**********FOR OFFICIAL USE ONLY**********

VACCINE	SITE (CIRCLE)	ROUTE	ICD-10	CPT	FEE
Influenza -**Afluria** *SEQIRUS*	LAT / RAT / LLT / RLT / LD / RD	IM	Z23	90656	$38
Influenza-**Fluarix** *GSK*	LAT / RAT / LLT / RLT / LD / RD	IM	Z23	90656	$38
Influenza-**Flulaval** GSK	LAT / RAT / LLT / RLT / LD / RD	IM	Z23	90656	$38

VIS DATE: Flu 8/06/21

ADMINISTRATION	√	CPT
PPO		90471
Illinois Public Aid/MCO		99211
Medicare/Medicare Advantage		G0008

Place Manufacturer sticker in gray box

ROSTER BILL (NO CHARGE)

☐ State of IL Employees on State of IL Health Insurance

☐ State of IL Retirees on State of IL Health Insurance/ Retirees & Survivors on TRAIL Medicare Advantage

CHARGE CLIENT *OR* OBTAIN INSURANCE INFORMATION FOR BILLING

☐ $38 State of IL Employees & Retirees **not** on State of IL Health Insurance

☐ $38 State of IL Dependent

☐ $38 NIU Students

RN SIGNATURE _____ **DATE** _____ / _____ / _____

CLERICAL:

AVAILITY ✓'d: _____/_____/_____ INITIALS: _____

MEDI ✓'d: _____/_____/_____ INITIALS: _____

CONSENT REVIEWED: _____/_____/_____ INITIALS: _____

I-CARE ENTERED: _____/_____/_____ INITIALS: _____

REMINDER: Have Client Complete Flu Questionaire Form; Make Copies of ID & Insurance Card; Print MEDI form & Attach all to Consent.

NURSE:

QA: _____/_____/_____ INITIALS: _____