NIU FLU - CLIENT CONSENT / REGISTRATION FORM

DeKalb County Health Department
Prevent • Protect • Promote

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: STATE OF ILLINOIS EMPLOYEE / RETIREE ON STATE OF IL HEALTH INS-ROSTER

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

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

PRIVATE INSURANCE/MEDICARE ADVANTAGE (COMPANY NAME): _____

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:*_____ ☐ SELF PAY

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): authorized to make the request: ☐ He leido y entiendo la version de esta hoya en español.

_____ _____ _____ / _____ / _____

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

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

VACCINE	SITE (CIRCLE)	√	ICD-10	CPT	FEE
Influenza -**Afluria** SEQIRUS	LAT / RAT / LLT / RLT / LD / RD		Z23	90686	$38
Influenza-**Fluarix** GSK	LAT / RAT / LLT / RLT / LD / RD		Z23	90686	$38

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

VIS DATE: 8/06/21

Place sticker in gray box Manufacturer

ROSTER BILL (NO CHARGE)

☐ State of IL Employee on State of IL Health Insurance
☐ State of IL Retiree on State of IL Health Insurance

CHARGE CLIENT *OR* OBTAIN INSURANCE INFORMATION FOR BILLING

☐ $38 State of IL Employee/Retiree **not** on State of IL Health Insurance
☐ $38 State of IL Dependent
☐ $38 NIU Students

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

I-CARE DATE _____ **INITIALS**_____

AMOUNT PAID _____ ☐ **CASH** ☐ **CHECK #** _____ ☐ **CREDIT CARD #** _____