0550114703

IMMUNIZATION CONSENT AND RELEASE

Care Dynamix Inc dba Flu Busters

CPT 90658
DX V04.81
G0008

First Name **MI** **Last Name**

Number & Street Address

City **State** **Zip Code**

Phone Number **Birth Date** **Age**

☐ Male ☐ Female

INFLUENZA (FLU) VACCINE

The flu vaccine does not protect against all strains of the influenza virus. The ability of flu vaccine to protect a person depends on the age and health status of the person receiving the vaccine, and the similarity or "match" between the virus strains in the vaccine and those in circulation. **The flu vaccine, which is made from dead influenza viruses, CANNOT give you the flu.** If you question whether you should receive the flu vaccine, please contact your personal physician. A small percentage of those vaccinated may experience minor side effects, such as soreness around the vaccination site for up to two days, headache or low-grade fever. Immediate, presumably allergic, reactions such as hives, angiodema, allergic asthma or anaphylaxis occur rarely after influenza vaccination. These reactions probably result from hypersensitivity to some vaccine component - the majority of reactions are most likely related to residual egg protein. Individuals with anaphylactic hypersensitivity to eggs should not be given an influenza vaccine. Guillian-Barre Syndrome (GBS) was noted to be a rare sequel of influenza vaccination during the 1976 "swine" influenza immunization program. Recent information does not indicate a clear rise of GBS in recipients of the flu vaccine compared to non-vaccines (Additional information relating to adverse reactions and side effects will be provided upon request). Please contact your personal physician in the event of a reaction. **Because of the potential for allergic reaction, you are asked to remain in the immediate area for observation purposes for the next 20 minutes after receiving the vaccine. You must answer the following questions prior to receiving the vaccine. CHECK "YES" OR "NO" FOR EACH QUESTION:**

1. Are you allergic to chicken eggs, mercury or sensitive to sulfites (found in cheese and wine)?	☐ Yes	☐ No
2. Do you currently have an acute infection or fever?	☐ Yes	☐ No
3. Have you ever had a severe reaction to a flu shot?	☐ Yes	☐ No
4. Are you pregnant or currently nursing a baby?	☐ Yes	☐ No
5. Do you have a severe blood clotting disorder?	☐ Yes	☐ No
6. Have you received any other vaccine within the past 14 days?	☐ Yes	☐ No

If you checked "Yes" on any of the above questions, please contact your physician and/or health care provider before receiving this vaccine.

WAIVER AND RELEASE

I hereby release and forever discharge and hold harmless Flu Busters and its directors, officers, employees, agents and assigns, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective directors, officer, employees, agents and assigns (hereinafter, collectively referred to as "Releasees") from any and all liability, claims, demands, and causes of action of whatever kind of nature, either in law or equity, which may hereafter arise from my receipt of the flu vaccine. I understand and acknowledge that this Consent and Release discharges Releasees from any liability or claim that may arise as a result of my receipt of the flu vaccine, with respect to any bodily injury or other injury, including any mental injury, illness, death, or property damage that may result. I understand that Releasees do not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance, in the event of injury, illness, death or property damage, unless otherwise expressly governed by and interpreted in accordance with the laws of the State of Georgia. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

PAYMENT INFORMATION

Any returned checks or denied credit card transactions are subject to the maximum allowed fee. Medicare MUST be your primary provider to be accepted or it will be denied and you will owe the full shot amount.

CASH AMOUNT $.

CHECK NUMBER

CHECK AMOUNT $.

If your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing free of $30.

CREDIT CARD AMOUNT $.

CREDIT CARD TYPE ☐ Visa ☐ MasterCard ☐ Discover

SIGNATURE

CREDIT CARD NUMBER

CREDIT CARD EXPIRATION /

SECURITY CODE

Your credit card billing address MUST be the same as it is listed above. If your billing address is different, please write your billing address on the reverse side of this form.

MEDICARE LETTERS PREFIX

MEDICARE NUMBER - -

MEDICARE LETTERS SUFFIX

NOTE: Your Medicare number could have a letters prefix AND/OR letters suffix, or neither. Please enter information as it appears on your card.

Your name at the top of this form MUST be the same as it is listed with your Medicare provider and as it appears on your Medicare Card. Participants with Medicare HMO must pay for services. I attest Medicare Part B is my PRIMARY medical coverage or I will be charged for the vaccination plus the service fee.

VOUCHER/TICKET NUMBER

NURSE INFO ONLY
☐ Right Deltoid Nurse Initials _____ Mfr. _____
☐ Left Deltoid Nurse Initials _____ Lot # _____

INFORMED CONSENT AND HIPAA PRIVACY INFORMATION

I have read the above Consent and Release and understand its provisions and applicability. I understand the benefits and risks of the flu vaccine as described and request that the vaccine be given to me or the person named above for whom I am the legal guardian. My medical record may be shared with my physician and/or insurer. I understand that Flu Busters will use and disclose my personal health information to treat me, to receive payment for the care it provides me, and for other health care operations, which generally include activities to improve the quality of care. I acknowledge that I have received a copy of Flu Busters' NOTICE OF PRIVACY AND CONFIDENTIAL PRACTICES. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

Signature (or Legal Guardian) _____ **Date** _____

Print Name _____ **Nurse's Signature** _____

BOTTOM COPY = Give to Flu Vaccine Recipient

TOP COPY = Return to Flu Busters