CWC Colorado Wellness Connection, LLC

CONSENT FORM

Influenza and/or Pneumonia Immunizations

Insurance Only - Please check (one) insurance plan to bill:

❑ Medicare Part B (not enrolled in HMO) ❑ Aetna ❑ Humana Gold
❑ Rocky Mtn. Health Plan ❑ Other Medicare Advantage _____ ❑ Other_____

Member Identification #: ☐☐☐☐☐☐☐☐☐☐ Are you a Kaiser member? ❑ Yes ❑ No

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ MI: ☐

Birthdate: ☐☐-☐☐-☐☐☐☐ (Month-Day-Year) Age: ☐☐ Sex: ❑M ❑F Phone # ☐☐☐-☐☐☐-☐☐☐☐

Street Address: _____

City: _____State_____Zip_____

PRECAUTIONS & CONTRAINDICATIONS **Please Check**

Have you ever had a flu shot before? ❑Yes ❑No

Do you have a history of hypersensitivity to chicken eggs or egg protein? ❑Yes ❑No

Do you have any hypersensitivity to any component of the vaccine, including thimerosal? ❑Yes ❑No

Do you have any of the following illnesses or conditions? ❑Yes ❑No
Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung Problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders.

Are you sick today? ❑Yes ❑No

Do you have a history of Guillain-Barre syndrome? ❑Yes ❑No

Have you ever had a bad reaction to another vaccine? ❑Yes ❑No

Please list the adverse reaction._____

Note – Pregnant women may not receive a pneumonia shot.

I have read/had explained to me the information about influenza and/or pneumonia as well as information regarding as influenza and/or pneumonia vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine/s and ask that the vaccine/s be given to me or to the person named above for whom I am authorized to make this request. I agree that Colorado Wellness Connection LLC shall have no responsibility or liability if I contract influenza, pneumonia, other respiratory diseases, or suffer any other adverse reaction following administration of the flu or pneumonia shot.

Notice of Privacy Practices: The information on this consent form is the extent of information Colorado Wellness Connection, LLC has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Any other release would require your authorization.

Signature of Responsible Person: _____ **Date:** _____

INSURANCE CODING INFORMATION			CLINIC USE ONLY
Influenza (Injectable)	**Flumist**		**Influenza Vaccine Diagnosis Code: V04.81**
Diagnosis Code: V04.81	V04.81		**Procedure Code: 90658/ 90471/ 90660 / 90473**
Procedure Code: 90658	90660	Vaccine	Injection Site (circle one): LD RD
Procedure Code: 90471	90467	Vaccine Administration	Nurse's Initials: _____
Amount Paid $_____			Mfg/Lot# _____Clinic_____
INSURANCE BILLING INFORMATION			**PNEUMOCOCCAL VACCINE**
Federal Tax ID: 84-1504515			Diagnosis Code: V03.82 Procedure Code: 90732 / 90471
Provider: Colorado Wellness Connection, LLC			Injection Site (circle one) RD LD
4960 E. Mineral Circle Centennial, CO 80122			Nurse Initials _____ Mfg/Lot #_____
303-738-8301			