Colorado Wellness Connection, LLC

Consent Form
Influenza and/or Pneumonia Immunizations

Please check (one) insurance plan to bill:

☐ **Medicare Part B (not enrolled in HMO)** ☐ **RR Medicare** ☐ **Humana Gold**
☐ **Rocky Mtn. Health Plan** ☐ **Other Medicare Advantage** _____

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

Patient's relationship to insured: **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** ☐

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

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Birthdate: ☐☐☐☐☐☐ **Age:** ☐☐ **Sex:** ☐ **M** ☐ **F** **Phone #:** ☐☐☐ ☐☐☐ ☐☐☐☐

Street Address:

City: **State:** **Zip:**

PRECAUTIONS & CONTRAINDICATIONS	**Please Circle**	
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 a history of Guillain-Barre syndrome?	Yes	No
Do you currently have a fever, respiratory illness or any other type of infection?	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 Diagnosis Code: V04.81 Procedure Code: 90658 Vaccine Procedure Code: 90471 Vaccine Administration **Amount Paid $**_____	**Influenza Vaccine** **Diagnosis Code: V04.81** **Procedure Code: 90658/90471** Injection Site (circle one): LD RD Nurse's Initials: _____ Mfg/Lot# _____Clinic_____
INSURANCE BILLING INFORMATION Federal Tax ID: 84-1504515 Provider: Colorado Wellness Connection, LLC 4960 E. Mineral Circle Centennial, CO 80122 303-738-8301	**Pneumococcal Vaccine** **Diagnosis Code: V03.82** **Procedure Code: 90732/90471** Injection Site (circle one) RD LD Nurse's Initials: _____ Mfg/Lot #_____