INFLUENZA VACCINE INFORMED CONSENT

How did you hear about Nova Health?

(check one) ☐ Postcard ☐ Newspaper Ad ☐Radio Ad ☐ Website ☐ Google ☐Social Media ☐ Friends/ Family Referral

Social Security Number:_____

Sex (check one) ☐ Male ☐Female

Date of Birth:_____ Age:_____

Last Name: _____ First Name: _____ MI: _____

Address:_____ Apt:_____

City:_____State:_____ Zip Code: _____

Home Phone: _____ CellPhone: _____

Screening Questionnaire

The following questions will help us determine if there is any reason we should not give you or your child the injectable influenza vaccine today. If a question is not clear, please ask your healthcare provider for clarification.

Please list any known allergies that you have:_____

Flu Vaccine Questionnaire

1. Do you feel ill or have a fever today? Yes ☐ No ☐ Unsure ☐
2. Have you ever had a severe allergic reaction to a influenza vaccine? Yes ☐ No ☐ Unsure ☐
3. Are you a health care or emergency medical services personnel? Yes ☐ No ☐ Unsure ☐
4. Do you have a history of Guillain- Barre' Syndrome? Yes ☐ No ☐ Unsure ☐
5. Do you have an allergy to eggs or egg product? Yes ☐ No ☐ Unsure ☐
6. Are you pregnant or planning on becoming pregnant in the next month? Yes ☐ No ☐ Unsure ☐
7. Do you have a chronic health problem such as: (asthma, heart, lung, kidney, neurologic or neuromuscular, liver disease, diabetes or blood disorder)? Yes ☐ No ☐ Unsure ☐
8. Do you have a weakened immune system because of HIV or another disease that affects the immune system; long term high dose steroid treatments, or cancer treatment with radiation or drugs? Yes ☐ No ☐ Unsure ☐
9. Are you taking any prescription medicines to prevent influenza? Have you taken antivirals in the last 48 hours? Yes ☐ No ☐ Unsure ☐
10. Do you live with, or expect to have close contact with severely immuno-compromised individuals living in a protective environment? Yes ☐ No ☐ Unsure ☐

VACCINE ADMINISTRATION RECORD AND WAIVER OF LIABILITY

I have read, or have had explained to me, the information in the 2020-2021 Influenza Vaccine Information Sheet (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

By:_____ Date:_____

Patient's or Patient's Representative's Signature

	Administer injectable flu vaccine today	☐ **Flulaval (Preservative Free)**	☐ **Fluzone (Preservative Free)**	☐ **Fluzone (High Dose)**
	DO NOT administer flu vaccine today			
Comments:		Ages: 6mo – 64 yr Dose: .5ml Route: R L Deltoid NDC: Lot# Exp:	Ages: 6mo – 64 yr Dose: .5ml Route: R L Deltoid NDC: Lot# Exp:	Ages: 65 yr+ Dose: .5ml Route: R L Deltoid NDC: Lot# Exp:
Patient Verified: Yes No				
Interviewer's Signature:				

nova HEALTH

PATIENT'S FINANCIAL RESPONSIBILITY STATEMENT

INSURANCE COVERAGE

We do our best to only accept patients' insurance plans that we are contracted with, but it is ultimately the responsibility of the patient to fully understand their plan's benefits including coverage, deductibles, co-payments, co-insurance and participating provider network stipulations. **I understand my plan details and accept financial responsibility for all services received, including any charges not covered by my insurance.** Initials: _____

UNINSURED COVERAGE

If you are uninsured, you may choose to participate in our self-pay program. Self-Pay deposits are due up front at the time of service. Self-Pay is not an option if we determine you have active insurance coverage and/or if you obtain retroactive coverage for the services provided during your visit. **I understand I have indicated no insurance coverage and accept financial responsibility for all services received, including any charges not covered by my initial self-pay deposit.** Initials: _____

COMMUNICATION AND CONSENT

1) **CONSENT TO MEDICAL CARE AND TREATMENT:** While at ICCO, LLC dba Nova Health, herein after referred to as "Nova Health", I consent to all medical and surgical care, examination, and tests determined to be necessary. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse suggested treatment, or if I leave against medical advice, I will not hold Nova Health or any individual responsible for any of the consequences.

2) **ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Nova Health for any services furnished to me by Nova Health and hereby assign Nova Health all assignable rights to payment for services rendered by Nova Health including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to Nova Health. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Centers for Medicare and Medicaid Services, insurers, and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by Nova Health, other providers, and insurers for treatment, payment and health care operations purposes. I understand that Nova Health participates in an electronic medical prescribing software(e-prescribing) and authorize Nova Health to send prescriptions directly to a pharmacy from the point of care. I agree that Nova Health may request and use my prescription history from other healthcare providers or third party payors for treatment purposes.

3) **FINANCIAL AGREEMENT:** I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

4) **CONSENT TO TEXT MESSAGING AND EMAIL:** In order to enhance patient's care and experience, Nova Health may contact you via phone call, voicemail, SMS text message, e-mail, or mobile application, some of which may be via automated means to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/ information. I understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing(including responding via text message "STOP"). Standard telephone minute and text charges may apply if we contact you.

5) **VIDEO SURVEILLANCE FOR SECURITY AND HEALTHCARE OPERATIONS:** At Nova Health, I understand and consent to video surveillance for security purposes and/or the practice's health care operations. I understand that the facility retains the ownership rights to the images and/or recordings. I understand that these images and/or recordings will be securely stored and protected.

By signing below, I hereby understand and agree with the above patient consent and authorization form. A copy may be given upon request.

By: _____ Date: _____

Patient's or Patient's Representative's Signature