PRIORITY URGENT CARE: VACCINE ADMINISTRATION INFORMATION AND CONSENT

CLINIC SITE: Town of Ellington/ Nicholas J. DiCorleto Jr Conference Room

DATE OF IMMUNIZATION: October 2, 2024

First Name:	Last Name:	Date of Birth:	Gender:
Address (Street, City, State, Zip):			
Home Phone:	Cell Phone:	Primary Physician:	

FLU SHOTS FOR TOWN OF ELLINGTON EMPLOYEES ARE BILLED TO YOUR INSURANCE.

People who are not town employees will be charged $40.00 for Flucelvax or $90.00 for Fluad or can provide their insurance information below.

INSURANCE ACCEPTED BY PRIORITY URGENT CARE					
☐	Aetna	☐	Harvard Pilgrim	☐	Medicare Part B
☐	Anthem BCBS	☐	Health New England	☐	Oxford
☐	CIGNA	☐	Humana	☐	Tufts
☐	ConnectiCare	☐	Husky – State of CT	☐	WellCare
☐	Golden Rule	☐		☐	CASH

Member ID

Medicare #

The following questions will help us determine if you should receive a vaccine today. Please answer each question by checking the appropriate boxes. If a question is not clear, please ask.	Yes	No	Don't Know
1) Are you sick today?			
2) Do you have allergies to Latex, medications, food, a vaccine component? (*i.e., Polyethylene glycol (which is found in some medications such as laxatives, and colonoscopy preps or Polysorbate, which found in some vaccines, film coated tablets, IV steroids)*?			
3) Have you ever had a serious reaction after receiving any vaccination or another injectable medication? [*Allergic reaction: This would include a severe allergic reaction (e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
4) Have you had a seizure, Guillain-Barre syndrome, brain or other nervous system problem?			
5) Are you immunocompromised or have a weak immune system?			

I have read or had had explained to me the information about influenza and the influenza vaccine. I have had the opportunity to ask questions which were answered to my satisfaction. I have no allergies or contraindications to receiving the influenza vaccine. I understand the risks and benefits of the influenza vaccine and I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I have had the opportunity to read the Privacy Policy and have received the Vaccine Information statement issued by the Federal Government. I understand that it is requested that I remain in the building for 20 minutes. Should I choose to leave earlier for any reason, I assume full responsibility for any adverse reactions that may occur.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE: In consideration of services provided by Priority Urgent Care (PUC), I hereby assign and transfer to Priority Urgent Care any and all rights which I have against insurance companies, governmental agencies or third-party payers for payment of charges for services provided by PUC to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third-party payers. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with PUC. I authorize said payments to be applied to any unpaid PUC balance for which I am responsible. I agree to pay all costs of collections, including reasonable attorney fees, on all past due amounts.

Patient or Patient Representative: _____ Date: _____Time_____am pm

If Patient Representative, please print name and relation to patient: _____Relationship_____

Vaccine Administered	Route	Dosage	Lot #	Exp. Date	Inj. Site	Immunizer:	Admin Date:
Influenza (<65)	IM				Deltoid: L R		
Influenza (65+)	IM				Deltoid: L R		