FLU PREVENTION PARTNERS a division of WPV, Inc.
59D Monroe Avenue, Pittsford, NY 14534
www.FluPreventionPartners.com

1. YOUR INFORMATION (PLEASE PRINT CLEARLY – All fields are required)

First Name _____ **Last Name** _____

Street _____ **City/State/ZIP** _____

Phone _____ **DOB** _____ **Age** _____ ☐ **Male** ☐ **Female**

2. INSURANCE INFORMATION (If you do not have a listed insurance, please go to 2b.)

☐ AETNA ☐ CIGNA ☐ LIFETIME BENEFIT SOLUTIONS ☐ UNITED HEALTHCARE
☐ BCBS (all) ☐ EXCELLUS ☐ MVP ☐ OTHER*_____
☐ CDPHP ☐ INDEP HEALTH ☐ UNIVERA ☐ **I am also a MEDICARE subscriber.**

*WPV Is not a provider for Medicaid, TRICARE, or NYS Empire Plan

SUBSCRIBER ID _____ Medicare ID (if applicable) _____

Policy Holder Name (if different than yourself): _____ DOB: _____
Relationship to policy holder: ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other

2b) PAYMENT WITHOUT INSURANCE: PAYMENT AMOUNT $_____ ☐ CASH ☐ CHECK #

3. SCREENING QUESTIONS

Have you ever received a flu vaccination before?	☐ **Yes** ☐ **No**
Have you ever had a serious reaction to a flu vaccination?	☐ **Yes** ☐ **No**
Are you allergic to eggs?	☐ **Yes** ☐ **No**
Do you have a fever today (over 101°F)?	☐ **Yes** ☐ **No**
Have you ever been diagnosed with Guillain-Barre Syndrome?	☐ **Yes** ☐ **No**
WOMEN ONLY: Are you pregnant?	☐ **Yes** ☐ **No**

4. CONSENT FOR FLU VACCINATION and HIPAA PRIVACY INFORMATION

I give my consent, voluntarily and of my own free will, to receive the influenza vaccination. I understand the benefits outweigh the risks and voluntarily assume full responsibility for any reactions that may result. I waive any claims against Workplace Vitality, Inc. (WPV), its officers, directors and employees arising out of my receipt of the flu vaccination. I have had an opportunity to review the Health Notice of Privacy Practices as well as the Flu Vaccine Information Sheet. I understand that it is my responsibility to notify my Physician of my receipt of this vaccination. I understand that as a part of service to its clients, WPV receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I also understand that WPV makes every reasonable effort to protect such identifiable health information, and that WPV requires a written request for the release of such information. This form constitutes such request and is valid for one (1) year from the date of signature below. In the case where disclosure of my completed flu immunization consent form is required to be in compliance with regulations involving my employment in a healthcare setting, WPV is authorized to disclose this consent form to my employer.

PARTICIPANT SIGNATURE _____ **DATE** _____

VACCINATION INFORMATION (To be completed by WPV)			
☐ **L Deltoid** ☐ **R Deltoid**	☐ **Preservative Free** ☐ **Senior High Dose**	☐ **Sanofi** ☐ **Seqirus**	**LOT ID**
Nurse Signature			**Date**