Personal Pharmacy Care (PPC-RX): Flu and Pneumococcal
Immunization Consent Form
Flu: V04.81 **Pneumococcal:** V03.82

Vaccine to administer: **Flu:** Yes No **Pneumococcal:** Yes No

Patient Name: _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ Phone #: ____-____-____

Facility: _____ Medicare #: _____

Secondary Insurance: _____ Policy #: _____

Circle One

1.) Have you ever had the Pneumonia Vaccine before? Yes No
Unsure
If "YES", has it been more than 5 years since that dose? Yes No
Unsure
If on Medicare and "UNSURE" please inform the pharmacy staff

2.) Do you have an allergy to either vaccine ingredient? Yes No
If "YES" which one? _____

3.) Have you had a serious reaction to the Flu or Pneumonia Vaccine before? Yes No
If "YES" which one? _____

4.) Do you have any fever or are you sick today? Yes No
If "YES" what are you symptoms? _____

5.) Do you have an illness that affects your immune system? Yes No

6.) Have you received a blood transfusion recently? Yes No

For women:

7.) Are you pregnant or likely to become pregnant in the next 3 months? Yes No

8.) Have you had a Mastectomy (Breast Removal)? Yes No
If "YES" please circle: Left or Right

I certify that I am at least 18 years old, or legal guardian of said patient and hereby give my consent to the staff of _____ facility, to administer the Flu and Pneumococcal Vaccine and to file the claim with Medicare if applicable. I have read the Vaccine Information Sheet (VIS) for my vaccine. I understand the risks and benefits of this vaccine and choose to assume the risk. As with all medical treatment, I know there is guarantee that I will not experience an adverse side effect from the vaccine. I fully release and discharge (Personal Pharmacy Care, LLC) from the liability for illness, injury, loss or damage that may result there from.

I AGREE TO WAIT NEAR THE VACCINATION AREA FOR APPROXIMATELY 20 MINTUES FOR OBSERVATION BY A NURSE.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF PERSONAL PHARMACY CARE NOTICE OF PRIVAY PRACTIVES, PATIENT RIGHTS AND RESPONSIBILITES, CMS MEDICARE DMEPOS SUPPLIER STANDARDS, AND PRODUCT INFO, SIDE EFFECTS AND USAGE.

Assignment of Benefits:
I request that payment of insurance be made directly to PPC-RX for enteral, urological, ostomy, diabetic supplies, vaccines and other billed Part B items or services that are ordered by my physicians while I am a resident of the above mentioned facility and that may be furnished to me by PPC-RX in accordance with such physician's orders. I acknowledge that this Authorization for Assignment of Benefits (AOB) is good indefinitely and that this Authorization may be revoked at any time. Any request for such revocation must be sent in writing to PPC-RX at the address listed below.

Information Release:
I authorize and request any holder of medical information about me to release and such information to PPC-RX, or to its contracted billing agencies as in necessary to determine benefit eligibility. I authorize and request that these agencies may review my clinical records to examine any personal and medical records held by the above facility and to make written copies of said records. PPC-RX and its contracted billing agencies acknowledge the responsibility to hold in the strictest confidence the information pertinent to the resident and agree not to release my information to any entity for purposes other than obtaining reimbursement for services provided or in the consent. I understand that I may revoke this consent by sending written notice to PPC-RX 11272 Hwy 57, Counce, TN 38326.

Resident Signature: _____ Date: ____/____/____

Signature if resident unable to sign: _____ Date: ____/____/____

DO NOT WRITE BELOW THIS LINE

Flu Vaccine/Mfr./LotNo. _____ Exp Date: _____ Flu: Injection Site: LD RD

Pneu Vaccine/Mfr./LotNo. _____ Exp Date: _____ Pneu: Injection Site: LD RD

Administered By: _____ Date: ____/____/____