Bloomfield Pediatric Care
43205 Woodward Ave Bloomfield Hills, MI 48306
Phone: (248) 451-0600 Fax: (248) 451-0700

Influenza Vaccination Informed Consent

Name of Patient: _____ Birth Date: _____

1. Have you ever had an allergic reaction to eggs? Yes No
2. Are you sick right now with something other than a cold? Yes No
3. Have you ever had a “bad reaction” to the influenza vaccination Yes No
4. Are you pregnant? Yes No

I have read the “Influenza Vaccination Facts” and would like to receive the Influenza Vaccination.

Patient/Parent Signature_____ Date:_____

Advance Beneficiary Notice

Note: You will need o make a choice about receiving these health-care items or services.

Your health insurance may not pay for the item(s) or service(s) that are described below. The plan that you have chosen as your health insurer does not necessarily cover all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

Estimated cost of the Influenza vaccine: $25

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s) that your health insurance does not.

Responsible party Signature:_____ Date:_____