Insurance Claim Form: Influenza Immunization Consent

GetA*FluShot*.com
A PROFESSIONAL HEALTH CARE LLC COMPANY, ESTABLISHED 1989 • COMMUNITY IMMUNIZATION PROVIDER SINCE 1991
SERVING OREGON & WASHINGTON STATES

Regence ☐	Providence ☐	Moda ☐	Kaiser ☐	Premera ☐	Lifewise ☐	Aetna ☐
Humana ☐	Medicare ☐	Pacific Source ☐	OR Medicaid ☐	United Health ☐	UMR ☐	Uniform Medical ☐

First Health Group #_____ ☐ Collective Health Group # _____ ☐

Other Insurance not listed above: _____

Primary Insurance ID

Secondary Insurance ID

Last Name

First Name

Your Street (or Mailing) Address where you receive your insurance paperwork

City State Zip Code

Telephone (000-000-0000) Date of Birth (Month-Day-Year)

Gender

M	F	NI
☐	☐	☐

Email Address: _____

	Y	N		Y	N
Have you had a flu shot before?	☐	☐	Are you allergic to a component of the vaccine?	☐	☐
Have you ever had a severe reaction to a flu shot?	☐	☐	Are you pregnant?	☐	☐
Have you had a history of Guillain-Barre Syndrome?	☐	☐	Are you sick today?	☐	☐

I have read about possible adverse reactions to the vaccine and the Vaccine Information Sheet, and additional copies have been made available to me. I have had the chance to ask questions, and all have been answered to my satisfaction. I request that the vaccine be given to me or the person I am authorized to represent, and I accept the benefits and risks. I release GetaFluShot (GAFS), its affiliates, and related parties from any claims related to this immunization. Per the No Surprise Billing Act, GetAFluShot.com follows Medicare pricing guidelines. I agree to pay for the vaccine and its administration if I do not have active or accepted insurance, and I consent to being contacted if more information is needed to process my consent or reimbursement.

Signature of responsible person	Relationship to Insured	Date Signed
X	☐ Self ☐ Spouse ☐ Child	

Nurse Initials_____ Deltoid Injection Site L R

Vaccine Information Sheet date: 1/31/2025

Affix Location Label Here

Affix Mfg/Lot Number & Expiration Label Here

Nurse Notes

Rev: 4/2026