Adult Flu - Fayette County Health Department **2017**		
		Location:
Name:		Birthdate:
Address:		
City:	Zip Code:	Phone Number:

I hereby authorize the Fayette County Health Department (FCHD) to release information related to this claim, to document data in Cornerstone, and I further authorize payment directly to FCHD from Public Aid, Medicare, private insurance or my employer. I understand I am responsible for payment if the payer indicated below does not pay. Patient acknowledges that they have received the "Joint Notice of Privacy Practices" dated September 23, 2013, and have been given the important information sheet from FCHD. VIS forms provided for each immunization. I have read the VIS sheet and give permission to administer the immunization.

Patient Signature:_____ **Date**:_____

Payment

☐ Medicare:_____ ☐ **Cash** ☐ **Check**

☐ IDPA #:_____ (Please refer in office.) Checked by Clerical: _____

OFFICE USE

☐ **FLU** (VIS 08/07/15)	Lot #_____ Exp. Date:_____	Site: Deltoid R L
☐ **PNEUMOVAX 23** (VIS 04/24/15)	Lot #_____ Exp. Date:_____	Site: Deltoid R L
☐ **PREVNAR 13** (VIS 11/05/15)	Lot #_____ Exp. Date:_____	Site: Deltoid R L
Nurse Signature:_____		Date:_____