High Dose 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 # UI830AB Exp. Date: 03/23/2018	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:______________