Tdap Immunization

Michigan Visiting Care

Vaccine Code: 90715
Tax ID: 38-6006309
Admin Code: 90471 ICD-9: V06.1
Vaccination Fee: $118.00

To Be Completed by ALL PATIENTS

CPI# _____

LEGAL Name: Last: _____ First: _____ MI: _____ Weight: _____lbs

Date of Birth: _____/_____/_____ Age: ____ Sex: Male / Female Phone Number: (_____) _____-_____

Address: _____ City: _____ County _____ State: _____ Zip Code: _____

Name of responsible party for patients under age 18:

Last: _____ First: _____ MI: _____

Please circle your answer on the right side of the page.

1. Are you sick today or running a temperature of 101.5 or over? ..... **YES NO**
2. Are you allergic to Epinephrine of Benadryl? ..... **YES NO**
3. Have you had the Td or Tdap shot before? ..... **YES NO UNSURE**
   If YES, when: _____
4. Have you ever had a reaction to DTaP, Tdap, Td, or any other vaccine, that required emergency measures? ..... **YES NO**
5. Have you ever had an allergic reaction (e.g., hives, breathing difficulties, shock) to anything that required emergency measures? ..... **YES NO**
6. Are you pregnant? ..... **YES NO**
7. Do you have a history of neurological disorder(s), epilepsy, encephalopathy (any degenerative disease of the brain), Gullian-Barre Syndrome or decreased levels of consciousness, i.e., comatose states? ..... **YES NO**
   If YES, please list: _____
8. Do you have a history of an Arthos reaction (i.e., a severe injection site reaction with hemorrhage or local necrosis typically developing 4-12 hours after a vaccination) following a previous dose of tetanus toxoid-containing or diphtheria toxiod-containing vaccine? ..... **YES NO**
9. Are you actively receiving immunosuppressive therapy (radiation, corticosteroids, antimetabolites, alkylating agents, and/or cytotoxic drugs)? (This may cause a reduced immune response to this vaccination). ..... **YES NO**

PATIENT CONSENT

I have read the information sheet about Tdap (Tetanus, Diptheria and Pertussis) and Tdap vaccine. I have had a chance to ask questions which were answered to my satisfaction. The information I have provided above is correct and true to the best of my knowledge. I understand the benefits and risks of Tdap vaccination and request that the vaccine be given to me or to the person listed below for whom I am authorized to make this request.

I understand that MVC can only bill certain insurances and that if I have an insurance MVC cannot bill, I am required to make payment to MVC at the time that services are provided. MVC will provide me with a receipt that contains information necessary to submit a claim to my insurance company in order to seek reimbursement directly. It is my responsibility to work with my insurance company to resolve any issues related to reimbursement. I understand that MVC cannot guarantee insurance reimbursement and that if my insurance company provides reimbursement it may only reimburse a portion of what I've paid today.

_____ Date_____
Signature of person to receive vaccine.

_____
Signature of person authorized for patient listed above **(if under 18 yrs of age or physically unable)**

❑ I have been provided with a copy of the Notice of Privacy Practice.

To Be Completed by MVC CLINIC STAFF

Immunization site: IM ❑ Deltoid ❑ Left ❑ Right

Vaccine Type: ❑ Adacel ❑ Other _____

Manufacturer: ❑ Sanofi ❑ Other _____

DOSAGE: 0.5cc

Lot Number: _____ **Nurse:** _____

INSURANCES ACCEPTED (Must Be Patient's Primary Coverage)

❑ Blue Care Network ❑ BCBSM PPO ❑ BlueCaid ❑ Cigna ❑ HAP (No HAP Senior Plus)
❑ Priority Health PPO or HMO ❑ Health Plus HMO / PPO / POS / MiChild ❑ PHP HMO / PPO

Insurance ID / Contract number: _____

Insurance GROUP number: _____

Name of Primary Insurance Holder: ❑ Same As Patient *(if different please enter name below)*

Last:_____First:_____Middle:_____

Patient's Relationship To Insurance Holder: ❑ Child ❑ Spouse

Address of Primary Insurance Holder: ❑ Same As Patient Address *(if different please enter address below)*

Street Address:_____

City:_____State:_____Zip Code:_____

PRIVATE PAY

Prompt Pay Fee: _____

❑ **Cash**

❑ **Check#:**_____

❑ **Credit Card**

❑ **MVC Voucher**

❑ **Corporate Pay**

❑ **UMHS Employee**

ID #:_____

❑ **UM Student**

ID #:_____

❑ **Other:**_____