Gvozden Pediatrics Flu Season Clinic 2021-2022

You **MUST** have an appointment scheduled to receive the flu vaccine. Call the office if you need an appointment or to add additional family members.

REQUIRED FORMS to BRING WITH YOU to receive vaccine

Children (only bottom form needed):

☐ **Flu slip** filled out and parent signature (below-one per child)

Parents receiving vaccine:

☐ **Demographic Form** (scroll down)

☐ Bring a **paper copy** of your current insurance card (front/back)

(Parents if your insurance is different than your child's we can NOT submit to insurance and you will be required to pay out of pocket-$40 fee)

☐ **Flu Slip**- filled out and signed (below—one per person)

I have read the above information about influenza and influenza vaccine, and I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to ☐ me or ☐ the person named below (under 18 years old) for whom I am authorizing to sign.

Person to Receive Vaccine	**For Office Use** **GVOZDEN PEDIATRICS**
_____ Name (Please Print) Person to receive Vaccine	Date of vaccine _____
_____ _____ Birthdate Age	Site of Injection _____
X_____ Signature (Person receiving vaccine or Parent or Guardian)	Initials

YOU MUST PROVIDE A PAPER COPY OF YOUR INSURANCE CARD AT YOUR APPT

GVOZDEN PEDIATRICS, PA

Today's date: _____

PATIENT REGISTRATION (please print legibly and fill out all fields)

Patient name: (First) _____ Middle_____ Last_____ Sex M /F

Billing address: _____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____

Cell Number_____

Email Address_____

Only fill out if subject/child is a minor—under 18 years of age

Name of policyholder: _____ DOB_____

Relationship to Patient: _____

CONSENT AND AUTHORIZATION AGREEMENT

Consent or treatment: I understand that medical treatment and examination is/or may become necessary for the patient by a health care provider. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the event of an emergency.

Assignment of Benefits: For patients with accepted insurance, I hereby authorize my insurance benefits to be paid directly to the provider. I am responsible for non-covered services. **Initials** _____

Release of Information: I hereby authorize the release of any medical information by the provider necessary to process claim forms or to aid in medical testing and treatment.

Agreement to pay services: I understand and agree that I am responsible to pay the charges for all services rendered by the patient on this registration.

If this account is turned over to a third party, I will be held accountable for all collection fees, attorneys' fees and court costs.

Fees: I understand that fees will be assessed for the following:

- Credit card payment on balances (3%)
- Returned Checks
- Failure to show up for any scheduled appointments
- Failure to provide at least 24-hours' notice when cancelling any scheduled appointments
- Billing of copays that are due at the time of service
- Claims resubmission

Notice of privacy practices written acknowledgement form

- I have been notified of GVOZDEN PEDIATRICS, P.A. Notice of Privacy Practices

I have read the above statements; understand and agree them. (Parent or Guardian must sign if patient is a minor)

Print name_____Relationship to patient_____

Signature_____ Date_____/_____/_____