LAKE FOREST ACUTE CARE

1025 W Everett Rd
Lake Forest, IL 60045

847-234-7950
www.LFAcuteCare.com

Influenza Vaccination Consent

Name (Last)		(First)	
Date of Birth	Age	M/F	
Address	City	Zip Code	State
Phone Number	Cell	Home	

Please answer the following questions:

☐ Yes	☐ No	Has the person to be vaccinated suffered from an allergy or sensitivity to egg, egg products, thimerosal (Mercury derivative used preservatives) ?
☐ Yes	☐ No	Is the person to be vaccinated sick today?
☐ Yes	☐ No	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
☐ Yes	☐ No	Has the person to be vaccinated ever had Guillain-Barre syndrome?

I give consent to Lake Forest Acute Care and it's staff to administer the 2023-2024 Seasonal Influenza Vaccine to me.

To be completed by parent/legal guardian if patient is under the age of 18

Printed Name:_____

Signature: _____

Date: ___/___/___

Office use only:

☐ **AFLURIA QUADRIVALENT MDV** **NDC: 33332-423-10 LOT #: P100581932 EXP:05/28/2024**

☐ **AFLURIA QUADRIVALENT PFS** **NDC: 33332-323-03 LOT #: AU1056A EXP:05/31/2024**

☐ **PRODUCT: _____ NDC: _____ LOT #: _____ EXP:____/____/____**

☐ **Left deltoid** ☐ **Right deltoid** **Administered by:_____Date: ___/___/_____**

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AUTHORIZATION AND RELEASE

AUTHORIZATION FOR TREATMENT: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and/or my dependents.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize directly to **Lake Forest Acute Care** for all benefits otherwise payable to me.

GUARANTEE OF PAYMENT: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services. You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, Lake Forest Acute Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

RELEASE OF RECORDS: I authorize **Lake Forest Acute Care** to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other healthcare operations which may be liable to me of my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

RECEIPT OF PRIVACY PRACTICE: I acknowledge that I have received and read the Notice of Privacy Practices of Lake **Forest Acute Care.**

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT NAME_____

PATIENT SIGNATURE_____ **DATE** _____/_____/_____

RESPONSIBLE PARTY_____ **DATE** _____/_____/_____

❑ **I WOULD LIKE MY MEDICAL RECORDS TO BE SENT TO MY PRIMARY CARE PROVIDER**

PRIMARY CARE PROIVIDER NAME:_____

ADDRESS:_____

PHONE NUMBER:_____**FAX:**_____

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NOTICE OF PRIVACY PRACTICES

We respect patient confidentiality and only release personal health information about you in accordance with the state and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

Privacy Contact – If you have any questions about this policy or rights, please contact our privacy officer.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To effectively provide care, there are times when we will need to share your personal information with others beyond Lake Forest Acute Care for:

Treatment – With your permission, we may use or disclose personal health information about you to provide, coordinate, or manage your care with any related services. This includes sharing information with parties outside of Lake Forest Acute Care with whom we are consulting or referring you to for further care.

Payment – Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Operations – We may use information about you to coordinate our business activities. This may include setting up appointments, reviewing your care, or training staff.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies – Sufficient information may be shared to address the immediate emergency you are facing.

Follow-up Appointment/Care - We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law – This would include situations where we have a subpoena, court order, or are mandated to provide public health information such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Director – We may disclose personal health information to a coroner or personal health examiner and funeral director for the purpose of carrying out their duties.

Government Requirements – We may disclose personal health information to a health oversite agency for activities authorized by law such as audits, investigations, inspections, and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information if requested by the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others – If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS AND RESPONSIBILITIES

You have the following rights under state and federal laws:

Copy of Records – You are entitled to inspect the personal health records we have generated about you. We may charge you a reasonable fee for copying and mailing your records.

Release of Records – You may consent in writing to the release of your records to others for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Contacting You – You may request that we send you information to another address or by alternative means. We will honor such request as long as it is reasonable, and we are assured it is correct. We have the right to verify that the payment information you are providing is correct.

Amending Record – If you believe that something in your record is incorrect or incomplete, you may request that we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment, you have a right to file a statement that you disagree with us. We will document all correspondence to your record.

Accounting for Disclosures – You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment or healthcare operation purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we are required to release. We will notify you of the cost involved in preparing this list.

Questions and Complaints – If you have any questions, or wish for a copy of this policy, or have any complaints, you may contact us in writing for further information. You may also complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Change in Policy – This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.