Flu Only Form Packet

Adult Immunization & Travel Clinic
101 Grove Street, Room 102
San Francisco, CA 94102
ph (415) 554-2625 fx (415) 554-2619
www.sfdph.org/aitc

PLEASE PRINT CLEARLY

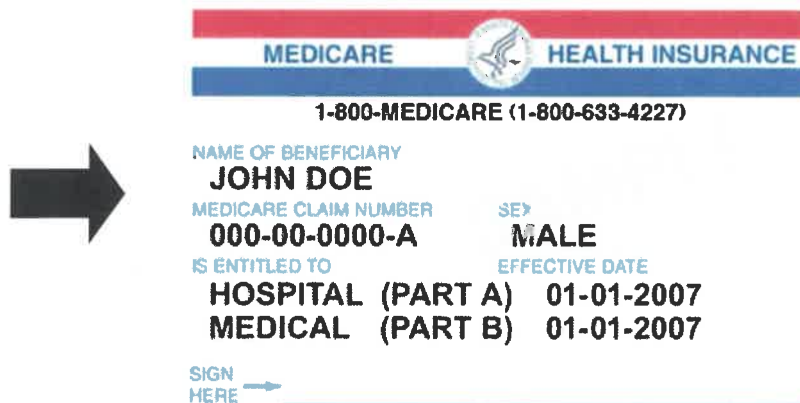
NAME ______________________________

BIRTHDATE ______________________________

SIGNATURE ______________________________

TODAY'S DATE ______________________________

The Medicare card (federal government issued health insurance) looks exactly like this



PLESE CHECK ONE:

☐ **NO**, I am **NOT** enrolled in any type of Medicare Plan

☐ **YES**, I have Medicare (read below)

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

FOR STAFF ONLY:

☐ Contracts on file

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT of PUBLIC HEALTH

TO OUR VALUED MEDICARE CLIENTS:

- Our Medical Director and Nurse Practitioner have "opted out" of Medicare
- To receive services at AITC, please sign and date both of the attached Private Contracts, one with our Medical Director and one with our Nurse Practitioner
- This contract is with AITC Immunization & Travel Clinic only. It does not affect your Medicare benefits anywhere else
- Unfortunately, if you do not sign a Private Contract with AITC, we will not be able to provide services to you

What signing the Private Contract means:

- To receive services at AITC, you must pay out-of-pocket at our listed prices, even if those services would be covered elsewhere by Medicare
- Medicare will not pay for any services received at AITC
- You agree not to submit a claim to Medicare
- AITC will not bill Medicare for you
- You are not required to sign a Private Contract with AITC. You are free to seek Medicare services elsewhere from a practitioner that has not opted-out

- THANK YOU FOR YOUR UNDERSTANDING

aitc IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT of PUBLIC HEALTH

FLU VACCINE FORM

101 Grove St, Room 102, San Francisco, CA 94102
(415) 554-2625 www.TravelClinicSF.org

(PLEASE PRINT)

NAME: (LAST)______________________________ (FIRST)______________________________

AGE: _____ BIRTHDATE: ____/____/________ PHONE: (_____) ______-__________ EMAIL: ______________________

ADDRESS: (STREET)______________________________ (CITY)____________________ (ZIP) __________

SEX AT BIRTH: ☐M ☐F GENDER IDENTITY: ☐M ☐F ☐Trans Male ☐Trans Female ☐Genderqueer / Gender non-binary ☐Not Listed

ONLY FOR 18 AND OLDER: How do you describe your sexual orientation or sexual identity?
☐Bisexual ☐Gay/Lesbian/Same-gender loving ☐Straight/Heterosexual ☐Questioning/Unsure ☐Not listed:________ ☐Decline to state

For All Flu Vaccines: Answer These Questions

Yes	No	
☐	☐	Have you ever had a flu shot before?
☐	☐	Have you ever had a bad reaction to a flu shot?
☐	☐	Are you allergic to eggs or egg proteins?
☐	☐	Are you allergic to thimerosal, formaldehyde, gelatin, hydrocortisone, Kanamycin, gentamicin, neomycin, or polymixin?
☐	☐	Do you have a blood clotting problem or take any blood thinners?
☐	☐	Are you taking any medication?
☐	☐	Have you ever had Guillain-Barre syndrome?
☐	☐	Are you pregnant now, or think you might be pregnant?
☐	☐	Have you ever fainted after getting a shot ?
☐	☐	Do you have a fever or acute illness today?
☐	☐	Have you eaten today?

For Flu Mist Nasal Spray Vaccine: Answer the Questions Above Plus These Questions Too

Yes	No	
☐	☐	Have you ever had the Flu Mist nasal spray vaccine before?
☐	☐	Have you ever had a bad reaction to the Flu Mist vaccine?
☐	☐	Are you younger than 2 years of age or older than 49?
☐	☐	Do you have asthma, wheezing, or lung disease?
☐	☐	Do you have anemia, leukemia, or another blood disorder?
☐	☐	Do you have heart disease, kidney disease, metabolic disease, or diabetes?
☐	☐	Do you have a weakened immune system? (e.g. cancer, HIV, immune deficiency)
☐	☐	Do you take medicine to suppress the immune system? (e.g. chemotherapy, prednisone)
☐	☐	Do you take anti-viral medicine to prevent influenza? (e.g. Tamiflu)
☐	☐	Do you live with or care for someone with a severely weakened immune system (e.g. someone on cancer chemotherapy or undergoing organ transplant)?
☐	☐	Are you under 18 years of age and regularly taking aspirin or aspirin-containing medicine?
☐	☐	Are you allergic to arginine?
☐	☐	Have you received any other vaccinations in the past 4 weeks?

I certify that the above information is correct to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions that I may have made in the completion of this form.
I have received a copy of the S.F. Dept. of Public Health Notice of HIPAA Privacy Practices. (Back of this form)
I understand the benefits and risks of seasonal influenza vaccination and want to receive the vaccine.

______________________________________ ____________________
Signature of patient/client/parent/Legal Guardian or Representative Date

______________________________________ ____________________ ____________________
Printed Name of Parent/Legal Guardian Signature or Representative Specify relationship Interpreter if applicable

STAFF USE ONLY

			Lot #	Site	
☐ IIV4	MDV	CPT 90688			
☐ IIV4	PFS/SDV	CPT 90686			
☐ LAIV4	IN	CPT 90672			
☐ ccIV4	PFS/SDV	CPT 90674			Nurse Signature Date
☐ ccIV4	MDV	CPT 90756			
☐ Other					

San Francisco Department of Public Health

SFDPH Summary Notice of HIPAA Privacy Practices and Acknowledgement of Receipt

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAASummaries.asp.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (Please see possible restrictions in the "Full Notice of Privacy Practices".)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask that copies of your health record be sent to someone (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how DPH employees may contact you.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, health information may be shared between treatment providers, including your health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as services received in substance abuse treatment agencies.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) Secretary of U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. (2) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 330, San Francisco, CA 94102, or call toll-free 1-855-729-6040. You will not be penalized in any way for filing a complaint.

Notice Regarding Unsecure Data Transmission by Email: DPH email does not provide secure data transmission as defined by HIPAA. Therefore DPH email transmission may not be secure against unauthorized disclosure.

By your signature on the reverse side of this page, you:

- Acknowledge receipt of the S F Department of Public Health "Full Notice of HIPAA Privacy Practices." .
- Acknowledge that DPH email may not be secure against unauthorized disclosure, and agree that DPH may send your health information to you via unsecure email, but only upon your specific request to receive such information by email.
- Agree that if the DPH services you received at AITC are to be billed to a third party, then your name, the services to be paid by the third party, and other information necessary to complete the billing, may be disclosed to the third party payor.

STAFF/WITNESS: If written acknowledgement is NOT obtained, please complete the following:

☐ Unable to sign ☐ Declined to sign ☐ Other, Describe:		
SIGNATURE OF STAFF WITNESS		DATE
PRINT NAME	DEPARTMENT/ORG	