[redacted] Pediatrics
[redacted].
[redacted] [redacted]

[redacted]
[redacted]
Phone: ([redacted]
Fax: [redacted]

Administration of FluMist™ Vaccine Agreement

By signing below, I agree that in the event that my insurance policy does not cover the FluMist™ vaccine, that I will be responsible for the cost regardless of what my insurance company states on the Explanation of Benefits.

Name: ______________________________ Date: __________________

Witness: ____________________________ Date: __________________

FLUMIST® ACKNOWLEDGEMENT FORM

I _____, have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, Inc. (BCBST), has determined that *FluMist*® (CPT™ Code 90660) may be an eligible expense under the terms of my health care benefits plan, but the reimbursement made by BlueCross BlueShield of Tennessee for *FluMist*® will not cover the entire cost of the service.

I have been informed about the potential costs of the referenced services. I understand that I will be responsible for all charges that exceed the Maximum Allowable Charge that may be available under the terms of my health benefits plan, if I elect to receive those services.

Signature of Patient or Responsible Person

_____

Date: _____

[redacted]
Pediatric Group

[redacted]
[redacted]16
[redacted]
[redacted]

[redacted], MD, FAAP
[redacted], MD, FAAP
[redacted], MD, FAAP
[redacted], MD
[redacted]y, CPNP
[redacted], PA-C
[redacted], CFNP

[redacted]
[redacted]7
[redacted]6
[redacted]7 Fax

[redacted], MD, FAAP
[redacted], MD, FAAP
[redacted], MD, FAAP
[redacted], MD, FAAP
[redacted], PA-C
[redacted], CFNP
[redacted], CPNP

IMMUNIZATION WAIVER

PATIENT NAME_____DOB_____

I have been informed that my insurance company may not reimburse for the vaccine indicated below, and I agree to assume full financial responsibility for the cost of the vaccine and administration.

I have also been informed that some insurance companies may require a co-payment for this service.

Please check any/all that apply:

[ ] **Menactra/meningococcal vaccine**

[ ] **Influenza vaccine**

[ ] **Other**_____

_____ _____

Parent/Guardian signature *Date*

302 846-8178

[redacted], MD; [redacted], MD; [redacted], MD; [redacted], DO
[redacted], NJ [redacted]

Mr. Manny Mouse
123 Bunko Lane
Wanamassa, NJ 07712

Dear Mr. Manny Mouse,

As a courtesy, we will bill your insurance for the Flu Vaccine for Manny Mouse. If the vaccine is not covered under your insurance, payment of $65.00 will be your responsibility, and due upon receipt of your bill. Flu Mist is also available, but not covered by most insurance companies. If you choose the Flu Mist, $40.00 is due at the time of service.

Sincerely,

[redacted] Pediatrics

Flu Shot	Date	Pt. Age	site on pt.	Nurse Initial	Parent/guardian Initials
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					
Flu Shot					