New Milford Visiting Nurse & Hospice

2020 Flu Informational Packet

It's Flu vaccination time once again! Included below is information about the day to help make it run smoothly. Please feel free to contact Jill at 860-354-2216 with any questions.

1. Consent form. It must be completed **legibly** with the primary insurance number and policy holder information.

2. Insurance: We have contracts with:
   a. Medicare
   b. Connecticare (including Medicare Advantage)
   c. Aetna & Aetna Medicare Advantage
   d. Anthem Blue Cross
   e. Blue Cross (other than Anthem)

*****Please be sure the correct Medicare information is given. If a managed medicare plan, we do not accept United Health Care.*****

3. Cash, check (Payable to: New Milford VNA, Inc.) and credit cards (Visa, Mastercard, Discover, American Express) can also accepted.

HIPPA (privacy statement): We would suggest posting it where people register so that clients can see what our agency does to secure their privacy.

Influenza Vaccine Information Statement: Each person receiving the vaccine should review this form.

PLEASE BE SURE THE CORRECT INSURANCE INFORMATION IS ON YOUR CONSENT FORM! If not, you will receive a bill for the vaccine.

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New Milford Visiting Nurse & Hospice

New Milford Visiting Nurse & Hospice
Pediatric Influenza Immunization Consent

Patient Name (minor child receiving vaccine)	**Gender** ☐ Male ☐ Female	Date of Birth
Address		
Street number and street name (No Post Office Box)	**City, State**	**Zip**
Parents home or cell ph#		

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID # and Policy Holder's name

☐ Aetna
☐ Anthem/Blue Cross
☐ Blue Cross (other than Anthem)
☐ Cigna (New Milford Town employees only)
☐ ConnectiCare
☐ Medicaid (Husky B/SCHIP)
☐ Other _____

Insurance ID # _____.
What is the name of the person who is the Policy Holder?
_____.
What is the Policy Holders date of birth? ____/____/____
Direct Payment
☐Other insurance not listed
☐Medicaid or No coverage (6 months to 59 months)
Paid by: ☐Cash ☐Check Amount Paid $_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Are you sick with a fever today? ☐ Yes ☐ No

Do you have an allergy to eggs or thimerosal? ☐ Yes ☐ No

Ever had a reaction to an influenza vaccine? ☐ Yes ☐ No

Ever been diagnosed with Guillian-Barre Syndrome? ☐ Yes ☐ No

I have read the Influenza Vaccine Information Statement 2020. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim. I have read the Notice of Privacy Practices. *I agree to pay all unpaid charges billed to me by New Milford Visiting Nurse & Hospice. I understand I will receive a bill from NMVNA for any portion of this claim my insurance company does not pay and I agree to pay the bill in full within 30 days of receipt.*

Parent Signature_____ Print Name: _____

STAFF USE ONLY

Place vaccine label here or complete: Vaccine Brand:_____ Lot # _____ Exp. Date:_____

Site: ☐L Arm ☐R Arm ☐L Leg ☐R Leg ☐ Intranasal

Administered by:_____ Date____/____/2020

New Milford Visiting Nurse & Hospice

New Milford Visiting Nurse and Hospice
Influenza Immunization Consent

Patient Name (as it appears on insurance card)	**Gender** ☐ Male ☐ Female	**Date of Birth**
Address (Street number and street name – no Post Office Box)	**City, State**	**Zip**
Home or Cell Phone **Email**	**Work Phone**	

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and Policy's Holder's name

☐ Aetna
☐ Aetna Medicare Advantage
☐ Anthem/Blue Cross
☐ Blue Cross (other than Anthem)
☐ ConnectiCare
☐ ConnectiCare Medicare VIP
☐ Medicare

Insurance ID #_____

What is the name of the person who is the Policy Holder?

_____

What is the Policy Holder's date of birth? ___/___/____

Direct Payment

☐ No insurance coverage

Paid by: ☐ Cash ☐ Check Amount Paid $_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you allergic to eggs or to the preservative thimerosal? ☐ Yes ☐ No
2. Have you ever had a reaction to any vaccine? ☐ Yes ☐ No
3. Have you ever been diagnosed with Guillain-Barre Syndrome? ☐ Yes ☐ No
4. Are you sick with a fever today? ☐ Yes ☐ No

I have read the Influence Vaccine Information Statement dated 08/15/19. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request.) I authorize the release of any medical or other information necessary to process the insurance claim or for the other public health purpose. I have read the Notice of Privacy Practices.
I agree to pay all unpaid charges billed to me by New Milford Visiting Nurse and Hospice. I understand I will receive a bill from NMVNA for any portion of this claim my insurance company does not pay and I agree to pay the bill in full within 30 days of receipt.

Signature:_____ Print Name: _____

STAFF USE ONLY

Place vaccine label here or complete: Vaccine Brand: _____ Lot # _____ Exp. Date: _____

☐Standard ☐High Dose ☐T-Free

Site: ☐ L Arm ☐ R Arm Administered by:_____ Date____/____/____

Short Version
1) Excludes Explanations of Listed Disclosures
2) Excludes Connecticut's Confidentiality Law

Effective Date August 1, 2013

NEW MILFORD VISITING NURSE ASSOCIATION INC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NMVNA is required by law to maintain the privacy of your health information and to provide you this detailed Notice of our legal duties and privacy practices relating to your health information. NMVNA shall abide by the terms of the Notice that are currently in effect. However, NMVNA reserves the right to change the terms of this Notice and to make the new provisions effective for all personal health information received and maintained by NMVNA now and in the future. We will provide you with a copy of the revised Notice upon request. In addition, a copy of the effective Notice will be posted at all times in the office with a date notifying you of the most recent update.

I. USES AND DISCLOSUES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

As a patient of NMVNA, information about you must be used and disclosed to other parties for purposes of treatment, payment, and health care operations. These uses and disclosures do not require your consent:

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and home health aides as well as by therapists, pharmacists, suppliers of medical equipment, assisted living staff, or other persons involved in your care. For example, we will contact your physician to discuss your plan of care.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request approval for services that will be provided to you.

For Health Care Operations. We may use or disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to past, present or future medical providers for the same purpose, for health care fraud and abuse detection or compliance

activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information for which you are consenting or as required by law or as allowed by HIPAA.

Individuals Involved in Your Care or Payment of Your Care, Emergencies, As Required By Law, Business Associate, Public Health Activities, Reporting Victims of Abuse, Neglect or Domestic Violence, Health Oversight Activities, To Avert a Serious Threat to Health or Safety, Judicial and Administrative Proceedings, Law Enforcement, Research, Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations, Disaster Relief, Military, Veterans and other Specific Government Functions, Workers' Compensation and other Benefit Programs, Inmates/Law Enforcement Custody, and Appointment Reminders.

Fundraising Activities. We may use certain limited information to contact you in an effort to raise funds for NMVNA and its operations. However, you may opt-out from receiving such communications.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you and that are offered by NMVNA or its affiliates and its contracted partners, including VNA Home Inc.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Most uses and disclosures of psychotherapy notes and of personal health information for marketing purposes and the sale of personal health information require an individual's authorization. NMVNA WILL NOT BE SELLING YOUR PERSONAL HEALTH INFORMATION AT ANY TIME. Uses and disclosures not described in this Notice will be made ONLY with your Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to NMVNA by you. At your request, NMVNA will supply you with the appropriate form to complete, if you wish.

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment or health care operations. You also have the right to

request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction (except if you restrict disclosures to family members or friends other than a conservator or listed health care agent). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment or in accordance with applicable law. However, you have the right to restrict certain disclosures of personal health information to a health insurance payor where the disclosure is for payment or health care operations and pertains to a health care item or service for which you (or any person other than the health insurance payor) have paid for the treatment in full.

Access to Personal Health Information. You have the right to request copies of your personal health information in any form you choose, provided that the personal health information is readily producible in that format. You have the right to request your personal health information electronically or have it directly transmitted to a third party specified by you per our capabilities. Your request must be made in writing. In most cases we may charge a reasonable, cost-based fee for preparing the copy, which will not exceed our labor costs in responding to your request and postage, if applicable.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by NMVNA who did not participate in the decision to deny.

Request Amendment. You have the right to request amendment of your health information maintained by NMVNA for as long as the information is kept by or for NMVNA. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by NMVNA, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for NMVNA; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by NMVNA.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by NMVNA or by others on our behalf. This includes disclosures made for treatment, payment and health care operations if the disclosures are made through an electronic health record.

To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice on our website, www._____.

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

Notification of Breach of Security. You have the right to be notified of an unauthorized disclosure of your unsecured personal health information and we will notify you of such a breach in accordance with our obligations under the law.

V. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights or wish to make any requests, opt-out of receiving certain communications or object to a disclosure, please contact Privacy Officer at 860-354-2216.

If you believe that your privacy rights have been violated, you may file a complaint in writing with NMVNA or with the Office for Civil Rights in the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints may also be made by phone to: 1-877-696-6775. We will not retaliate against you if you file a complaint.

I acknowledge that I have read or had this Notice explained to me. I understand this Notice and have had the opportunity to ask questions regarding any matters of concern and signing it voluntarily.

OPTIONAL: These are the immediate family members that I do not want to obtain access to my personal health information:

_____

Print Name: Date

_____

Print Name: Date

If applicable, Conservator or Health Care Agent

G:Wordfiles/HIPAA Mega Rules

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's **www.cdc.gov/flu**