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Cervarix Vaccine Responsibility / Authorization

Patient Name: _____

Patient DOB: _____

Today's Date: _____

Cervarix Vaccine:

The Cervarix vaccine is given in three (3) doses over the course of six months.

First dose given during today's office visit: _____

Second dose given one (1) month after the first dose: _____

Third dose give six (6) months after the first dose: _____

Karle Medical Group, P.C. will bill the administration fee (CPT 90471) in addition to the cost for the Cervarix (CPT 90650) vaccine itself to your insurance company.

I, _____, have read the patient information sheet and would like to receive this vaccination.

If the costs of the vaccine, and/or any administration fees, are not covered by my Health Insurance Company, I and/or my parent/guardian agree to pay for the full price of the vaccine and its administration at the time of the first dose. I understand that if the recipient of the vaccine is outside of the ages of 9-26 years old, it is unlikely that any insurance company will cover the fees related to the vaccine.

_____

Patient/Parent/Guardian/Responsible Party