AMITA HEALTH®
RESURRECTION MEDICAL CENTER
CHICAGO

Last Name: _____First Name: _____ Middle Initial: _____

Address:_____City/State:_____Zip Code:_____

Daytime Phone Number: _____Email (optional)_____

Date of Birth: _____ Age: _____ Gender: □ Male □ Female

**For Office Use Only**

Total Amount $

□ Cash

□ Check #

□ Medicare (see below)

□ Client is paying for the following person(s): _____

□ Client is unable to pay. See attached waiver.

**For Medicare Patients Only**

**Medicare Part B number exactly as it appears on the Medicare Card**

□ **Medicare** | | | | | | | | | | | |

**My signature below indicates my approval for AMITA Health Resurrection Medical Center to bill Medicare for the cost of today's flu vaccine. I understand that Medicare Part B provides coverage for one flu shot per year.**

_____ _____
Signature of person to receive vaccine or person authorized to make request Date