



CONSENT FOR TREATMENT

1. I have been informed and I understand that the registered Nurses providing health care services to me, my family, and as my dependents are not employees, agents or apparent agents of shotfairy.com LLC but are independent contractors.
2. I am aware that the practice of medicine and vaccination/immunization is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any health care or vaccination/immunization service.
3. I understand that my medical records are protected under federal and state law and may be disclosed without my written consent for the purposes of treatment, payment, verification of vaccination/immunization, and healthcare operations. I give my authorization for the release of such medical records and medical information for the above purposes and as needed to process my claim for reimbursement from my health insurance plan. I further understand that the specific type of information to be disclosed may include diagnosis, prognosis, treatment for physical or mental illness, treatment for alcohol or substance abuse, or HIV testing.
4. I have completed the client history form accurately and completely. If I have completed the client history form on behalf of someone else, such as my child, spouse, or someone for whom I have medical power of attorney. I have authority to provide such information and I have provided such information accurately and completely.
5. I hereby warrant that I never have had an adverse reaction to a vaccination or immunization. In addition, if I am registering another individual for vaccination, I hereby warrant that I have authority to do so and that the individual who I am registering for vaccination/immunization, such as my child, spouse or someone for whom I have the medical power of attorney, never has had an adverse reaction to a vaccination or immunization.
6. I hereby warrant that I do not have a bloodborne illness or disease such as hepatitis or HIV/AIDS and that any person I am registering for vaccination/immunization does not have a bloodborne illness or disease such as hepatitis or HIV/AIDS.
7. I have been informed and I understand that there are risks and complications to any medical procedure including vaccination/immunization. I understand that an adverse reaction may occur as a result of the vaccination/immunization process. I have reviewed and understand the benefits and risks to vaccination/immunization outlined at www.cdc.gov/vaccines I have been instructed to and I will contact my

physician in the event of an adverse reaction. In the event of an emergency, I have been instructed to and I will call 911.

8. In the event I cancel an appointment less than four hours before the visit, I will be charged a \$35.00 cancellation fee and I hereby consent to such fee.

9. I hereby request and consent to the performance of vaccination/immunization medical services including but not limited to the administration of medications and/or injectibles via a needle and syringe or nasal spray by shotfairiy.com LLC in my home. In addition, if I am registering another person for such services in the home such as my child, spouse or someone for whom I have the medical power of attorney, I hereby warrant that I have the authority and permission to request and consent to the performance of vaccination/immunization medical services including but not limited to the administration of medications and/or injectibles via a needle and syringe or nasal spray by shotfairiy.com LLC for such person in the home.

10. By clicking the box marked yes, I am affixing my electronic signature and acknowledging that I have read, understood, and agreed to the foregoing. I have been given the opportunity to ask any questions that I may have and those questions have been answered to my satisfaction. I acknowledge that I have been fully apprised of the risks and benefits of vaccination/immunization medical services and I have elected to proceed with the vaccination/immunization medical service.