Patient Name _____ *date of birth* _____

Chesapeake Women's Care

HPV Vaccine (Gardasil)

Dear Patient,

The HPV vaccine is available in our office to our patients. The CDC's recommendation is to offer the vaccine to patients between the ages of 9 and 26. Other criteria are involved; you and your provider will decide if the vaccine is right for you. Attached to this letter is an information sheet about this vaccine.

The vaccine is given in a series of 3 injections over a 6 month period. The 2nd and 3rd doses should be given 2 and 6 months (respectively) after the 1st dose.

Most insurance carriers pay for this vaccine for women in the approved age group. We will be happy to submit the claim to your insurance on your behalf. However, if the vaccine is not covered, or is subject to a co-pay or a deductible, you are responsible for the balance for each injection you receive. We will bill you for that amount if applicable. Each dose of vaccine is $165.00 plus a $25.00 administration fee.

By signing below you agree to receive the series of HPV vaccines. You also agree to the payment terms as stated above.

Patients:

Please keep the attached CDC Vaccine Information Statement for the HPV vaccine. Sign and initial the consent for the vaccine below. Thank you.

_____ I have received and read the CDC Vaccine Information Statement for the HPV Vaccine. I have had the opportunity to ask questions and understand the benefits and risks of the HPV vaccine.

_____ I request the HPV Vaccine series to be given to me. I understand and agree to the payment terms as stated above.

Printed Patient Name: _____ Date: _____

Signature: _____

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