ADM

Date: _____/ _____/ _____

Patient Registration Form (Please Print)

Patient Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth _____ Last 4 digits of SSN _____ ☐ Male ☐ Female

Patient Cell Phone _____ Home/Alternate Phone _____

Address: Street _____ Apt/Unit: _____

City _____ State _____ Zip Code _____

E-mail Address _____

Race: ☐ Black/African American ☐ White ☐ Other _____

Marital Status: ☐ Legally Married ☐ Single ☐ Widow ☐ Divorced

Do you have a LOCAL Primary Care Physician? ☐ Yes ☐ No *(If yes)* Name: _____

Insurance Company Name: _____ Policy #: _____

Subscriber Name: _____ Subscriber Sex: ☐ M ☐ F

Patient Relationship to Subscriber: _____ Employment Status: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Decline to Specify

Emergency Contact 1: Name _____

Phone Number _____ Relationship _____

Do you have a different **Mailing/PO BOX** Address? (If yes) Street: _____

City _____ State _____ Zip Code _____

Reason for Visit: _____

Guardian/Parent Info

Please complete **ONLY** if Patient is under the age of 18

Guardian Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth _____ ☐ Male ☐ Female

Relationship to patient: ☐ Mother ☐ Father Other: _____

Last 4 digits of Social Security Number _____ Cell Phone _____

Are you employed? ☐ Yes ☐ No Employer Name: _____ Phone# _____

Occupation _____

Mailing/Billing/PO BOX Address (If different than patient's) _____

City _____ State _____ Zip Code _____

Patient Label

CNT

I have been given the Vaccine Information Sheet (VIS) or the fact sheet (issuance date _____).
I have read the sheet and have had my questions answered to my satisfaction regarding the COVID-19 Vaccine, including risks, benefits, and possible adverse reactions or complications associated with the vaccine.
I, hereby, consent to and authorize _____ facility through its designated agents or representatives, to administer to _____ *(print full name),* the COVID-19 Vaccine.
I acknowledge that no guarantee or assurance has been made to me regarding the vaccine. The facility, by making this vaccine available to me, provides no warranty to me with respect to the vaccine.

☐Yes ☐No Have you ever had an allergic reaction to eggs, gelatin, neomycin, streptomycin, or a previous vaccination?
☐Yes ☐No Do you have a history of Guillain-Barre Syndrome?
☐Yes ☐No Have you had a serious reaction after receiving a vaccination? Do you have history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?
☐Yes ☐No Are you a minor? (Less than 18 years of age)

I currently have the following symptoms of COVID-19 (answer yes or no to each symptom).

☐Yes ☐No Fever or chills
☐Yes ☐No Cough
☐Yes ☐No Shortness of breath or difficulty breathing
☐Yes ☐No Fatigue
☐Yes ☐No Muscle or body aches
☐Yes ☐No Sore throat
☐Yes ☐No New loss of taste or smell
☐Yes ☐No Congestion or runny nose
☐Yes ☐No Nausea or vomiting
☐Yes ☐No Diarrhea
☐Yes ☐No Headache

☐Yes ☐No I have knowingly had unprotected exposure to anyone who is positive for COVID-19 in the past 14 days.
☐Yes ☐No I have a history of travel within the past 14 days outside the continental United States or any cruise travel.
☐Yes ☐No I have been recently tested for COVID-19 and I am still awaiting test results.
☐Yes ☐No I do not qualify to return to work due to a previously positive COVID-19 test.

If two COVID-19 doses are required, I agree to return for the 2nd dose.

☐Yes ☐No If this is your second dose, did you suffer any negative reaction to the first dose?

**If yes to any of the above, do not administer vaccine without physician's approval.*

Provider/Clinician Name Who Approved			Date/Time
Recipient Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

For Person Administering Use Only:

_____
Injection Site (Dose #1)

_____ _____ _____
Expiration Date | Manufacturer/Lot Number | Amount Administered

Signature of person administering vaccine	Title	Date/Time

_____ _____
Injection Site (Dose #2) | Date of Dose #1

_____ _____ _____
Expiration Date | Manufacturer/Lot Number | Amount Administered

Signature of person administering vaccine	Title	Date/Time

Patient Label

CNT

1. CONSENT TO TREATMENT AND ACKNOWLEDGEMENT:

I certify that I am: (a) the patient and at least the age of majority to consent to this treatment; (b) the legal guardian of the Patient; or (c) a person authorized to consent on behalf of the patient where the Patient is not otherwise competent to consent. I hereby give consent to this Facility and the healthcare professional administering the COVID-19 vaccine at the Facility for the Patient to be vaccinated with a COVID-19 vaccine. I understand that these services may be performed by independent contractors, students, or others at the Facility who have received appropriate training but who are not employed by the Facility. I have read or had explained to me the risks and benefits of and have received the Emergency Use Authorization (EUA) fact sheet or Vaccine Information Statement (VIS) for the COVID-19 vaccination I have selected. I have had the opportunity to ask questions about the COVID-19 vaccine and acknowledge that such questions were answered to my satisfaction. I further acknowledge that I have the right to withdraw my consent prior to the receipt of the COVID-19 vaccine. I have been advised that the Patient should remain near the vaccination location for observation after administration of the COVID-19 vaccine. I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made as to the result of, outcome of, or reaction to the COVID-19 vaccine. I acknowledge that the Facility and healthcare provider administering the COVID-19 vaccine are not liable for any potentially adverse reaction I may have to this vaccine. I understand that I am to report all adverse outcomes to the U.S. Department of Health & Human Services.

2. CONSENT TO RELEASE HEALTH INFORMATION:

I acknowledge that the Facility may disclose the Patient's vaccination information to the state's vaccination registry, to the state's health information exchange, or any state, local or federal governmental agency or body, as may be required by state law for purposes of public health reporting. I hereby give consent to the Facility to release the Patient's vaccination information to any local or state governmental body, as required by law. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I further acknowledge that I may be able to opt out of having the Patient's vaccination information disclosed to state or local government, as permitted by and in accordance with state law.

I acknowledge that this Facility uses an electronic medical record and that the electronic medical record contains information about the Patient's health from past, current and future health care providers. I give consent to the Facility to release this health information as necessary through the Facility's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Facility and to Patient's past, current and future health care providers to effectuate care; and (2) to Patient's health insurer and/or third-party payer to effectuate payment. I understand that these people will have access to all of the Patient's health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back the consent in this paragraph at any time, except if the Patient's health information has already been released to someone.

3. NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Facility's Notice of Privacy Practices and consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. ASSIGNMENT OF BENEFITS

I understand that the Facility may charge and bill an administration fee for administering the vaccine to my insurer or third-party payer. I further understand that I will not be responsible for paying any portion of this administration fee out of pocket, regardless of whether I have insurance and regardless of whether my insurance covers the vaccine. To effectuate this payment, I hereby assign to the Facility all of my rights and benefits under existing policies of insurance providing coverage and payment for any expenses incurred as a result of services and treatment rendered by the Facility or any independent contractor. I authorize direct payment to the Facility or to any independent contractor of any insurance benefits otherwise payable to or on behalf of myself. If I am eligible for Medicare, I request Medicare services and benefits. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment of this administration fee.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative		Date	Time
Relationship to Patient	Interpreter, if Utilized	Date	Time
Witness Signature		Date	Time

Patient Label

Medicare Secondary Payer Questionnaire

Patient Name : _____ DOB: _____

Are you receiving Black Lung (BL) Benefits?	YES	NO	
If yes; Date benefits began: Current Visit Due to BL Signs/Symptoms:	YES	NO	
Are the services today being paid by a government research program?	YES	NO	
Has the Dept of Vet Affairs authorized & agreed to pay for this service?	YES	NO	
Today's visit: Is it due to a work related accident/condition?	YES	NO	
If yes; Date of injury:			
Name of WC:			
Claim address for WC:			
Policy or ID# for WC:			
Employer name and address:			
Today's visit: Is it due to a **non**-work related accident/condition?	YES	NO	
Date of non-work related injury:			
Is "no fault" insurance available?	YES	NO	
Name & address:			
Claim #			
Are you entitled to Medicare based on End Stage Renal Disease	YES	NO	
Are you entitled to Medicare based on ---------->	AGE	DISABILITY	
Are you currently employed?	YES	NO	NEVER
If no, date on bottom of Medicare card "coverage starts" date:			
If, yes; Employer name & address			
Do you have a spouse who is currently employed?	YES	NO	NEVER
If no, date on bottom of Medicare card "coverage starts" date:			
If, yes; Employer name & address			
Do you have group health plan (GHP) coverage based on a current employment?	YES	NO	
If, yes; ☐ Self ☐ Spouse ☐ Other Family Member			
Insurance name & address:			
Policy ID:			
Group # :			
Subscriber's Name: Relation to Pt:			
Name and Address of Employer Insurance is through :			
Does the employer sponsor 100 or more employees?	YES	NO	
If, yes; **GHP Primary**			
Patient's Primary Payor is?			