REGISTRATION, ACKNOWLEDGEMENT & CONSENT FORM

50210 - __ __ __ __ __

INSTRUCTIONS: MARCOMM - 1) Please add specific instructions for your patient based on your specific workflow/ process. 2) Add HM name and change font color as noted below. 3) A HM logo may be added.
Do not delete any fields or info in the form.
Please complete and bring with you to your appointment

Date: ______________________________ **Birth Date:** ______________________

Patient Name (last, first, middle): ____

If uninsured, you must check the box below to attest that the following information is true and accurate:
□ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program, please provide either (a)valid Social Security number, (b)state identification number and state of issuance, OR (c) a driver's license number and state of issuance.

Social Security Number	or State Identification Number & State	or Driver's License Number & State

SCREENING QUESTIONS

	YES	NO	DON'T KNOW
1. Are you sick today?	◯	◯	◯
2. Do you have any allergies to any contents in this vaccine?	◯	◯	◯
3. Have you ever had a severe allergic/ anaphylactic reaction to any vaccine?	◯	◯	◯
4. Do you have a bleeding disorder or are you on a blood thinner?	◯	◯	◯
5. Are you immunocompromised or on any medications that affect your immune system?	◯	◯	◯
6. Have you received a COVID-19 vaccine previously?	◯	◯	◯
7. Female Patients:			
a. Are you or could you be pregnant?	◯	◯	◯
b. Are you planning to become pregnant?	◯	◯	◯
c. Are you breastfeeding?	◯	◯	◯
8. In the past two weeks, have you tested positive for COVID-19 or have you currently been exposed to someone with COVID-19?	◯	◯	◯
9. If you were diagnosed with COVID-19 in the past 90 days did you receive antibody therapy or convalescent plasma for treatment of your COVID illness?	◯	◯	◯
10. Have you had any vaccinations in the past 14 days?	◯	◯	◯

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Patient Name: ______________________________ **Birth Date:** ____________________

AUTHORIZATION FOR PAYMENT

I authorize release of my personal, billing and medical information to third party payers, insurance companies or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

DISCLOSURE OF RECORDS

I understand [insert name of ministry] may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated by [insert ministry], my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state/federal registries, for purposes of treatment, payment or other health care operations. I also understand that [insert Ministry] will use and disclose my health information as set forth in the ministry Notice of Privacy Practices (a copy is available upon request).

I agree that [insert ministry] and its business associates may contact me by any phone number provided by me or associated with my health record, including cell phone numbers, which could result in charges to me. [insert ministry name] also may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

Patient Name: ______________________________ **Birth Date:** ____________________

Signature of Patient: ______________________________ **Date:** ____________________

Signature of Parent or Guardian: ______________________________ **Date:** ____________________

PATIENTS WHO ARE 16 and 17 YEARS OF AGE

I consent for [insert ministry] to provide the COVID-19 vaccine to the patient identified above. I acknowledge I read this document as well as the Fact Sheet for Vaccine Recipients.

Signature of Parent or Guardian______________________________ **Date:** ____________________

ACKNOWLEDGEMENT

I was provided the Fact Sheet for Recipients for the COVID 19 vaccine I am receiving. I read and/or had explained to me the information provided about the vaccine. I was given the chance to ask questions and any questions I had were answered to my satisfaction. I understand the risks and benefits of the vaccination and I am voluntarily choosing to get the vaccination.

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine, I will be monitored for 30 minutes.
I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.