

COVID Vaccine Intake Consent Form



Patient Information

Last Name		First Name			
Date of Birth	Gender	Phone Number	Email Address		
Address		City	State	Zip	SSN*
Race (circle one)	White	Black	Hispanic	Other _____	
Primary Care Provider Name (PCP)		PCP Phone #	PCP Fax #		
PCP Address		City	State	Zip	

*SSN and state of residence, or state identification/driver 's license is needed to verify patient eligibility. Claims submitted without a SSN and state of residence, or state identification/driver 's license may take longer to verify for patient eligibility.

If you are part of a Senior Facility clinic, are you a: resident or an employee/staff ?

If someone else manages health decisions on behalf of the resident, please provide the following:

Caregiver or Financially Responsible Party Name	Relationship	Phone Number
---	--------------	--------------

Prescription Insurance

Patient is primary card holder (check box if yes)

Pharmacy Insurance Provider	ID#	Group	BIN	PCN
-----------------------------	-----	-------	-----	-----

Medicare Fields: (Note: COVID Vaccine will be billed at Part B through your Medicare provider)

Yes No

Is the patient age 65 or older or is the patient Medicare Eligible?

Medicare Part B Number (red, white, and blue card)

Medical Insurance:

Yes No

Medical Insurance Provider	ID#	Group	Is the Patient the Primary Cardholder?
----------------------------	-----	-------	--

COVID-19 Screening Questions		Yes	No	Don't Know
1.	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COVID Vaccine Intake Consent Form



COVID-19 Screening Questions (continued)		Yes	No	Don't Know
3.	Do you currently or have you in the past 14 days had a fever, cough, shortness of breath, or loss of sense of taste and smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	For women, are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Mainline Pharmacy/Blairsville Pharmacy/Bushy Run Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under

Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. DISCLOSURE OF RECORDS: I understand that Mainline Pharmacy/Blairsville Pharmacy/Bushy Run Pharmacy 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 my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Mainline Pharmacy will use and disclose my health information as set forth in the Mainline Pharmacy/Blairsville Pharmacy/Bushy Run Pharmacy Notice of Privacy Practices (copy is available in-store). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X

Signature of patient to receive vaccine or person authorized to make the request

Date

Vaccine Administration Information for immunizer/Pharmacist use only

Administration Date	Vaccine	VIS Date	Manufacturer	
Lot#	Exp. Date	Route	Site	Volume (ml)
Administering Immunizer Name & Title		Administering Immunizer Signature		