COVID-19 Immunization Screening and Consent Form for New Patient

Recipient Name (please print)		Preferred Name		
DOB	Sex Assigned at Birth	Marital Status (Please circle) S – Single M – Married D – Divorced W – Widowed SE – Legally Separated P – Life Partner V – Civil Union U – Unknown		
Address City State Zip		Email Address:		
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language	
Ethnicity (Please circle) HIS – Hispanic Origin NHL – Non-Hispanic Origin DECL – Declined UNK - Unknown		Race (Please circle) AIA – Native American or Alaskan BAA – African American Black NHP – Native Hawaiian or Pacific Islander DECL – Declined	ASN – Asian WHT – White OTH – Other or Multiracial	
Clinic/Office Site Where Vaccine is Administered		Primary Care Physician Address/Phone Number		

Insurance Information

Insurance Carrier:	Insurance#	Insured Name:
Medicare#	Medicaid#	Insured DOB:
Relationship to Insurer: ☐Self ☐Spouse ☐Child ☐Other		Insured Gender:
Secondary Insurance Carrier:	Insurance#	Insured Name:
Medicare#	Medicaid#	Insured DOB:
Relationship to Insurer: ☐Self ☐Spouse ☐Child ☐Other		Insured Gender

Social History

Tobacco: ☐ No ☐ Yes ☐ Quitted	**Alcohol**: ☐ No ☐ Yes	**Substance Abuse**: ☐ No ☐ Yes **Explain**: _____

Others

Preferred Pharmacy:	Pharmacy Phone #:	Previous/Refer PCP:

Agreement

I hereby authorize direct payment of medical benefits to Rendr Physicians for services rendered by the office.
I understand that I am financially responsible for any balance if my insurance is terminated or the service is not covered.

Printed Name of Patient/Guardian / Authorized Representative

_____

Relationship

_____

Signature of Patient/Guardian / Authorized Representative:

_____

Date

_____

Last, First Name: _____ **DOB:** _____

Screening Questionnaire				
1.	Are you feeling sick today?	☐ Yes	☐ No	
2.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* Date: _____	☐ Yes	☐ No	☐ Unknown
4.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injections, or shot or to any component of the COVID-19 vaccines, or a severe allergic reaction (anaphylaxis) to anything?	☐ Yes	☐ No	☐ Unknown
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? *If yes, how long ago was your most recent vaccine?* Date: _____	☐ Yes	☐ No	☐ Unknown
6.	Are you pregnant, considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown
7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Unknown
8.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No	☐ Unknown
9.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine? ☐Moderna ☐Pfizer ☐Janssen	☐ Yes	☐ No	

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

I acknowledge and consent that information regarding my identity and all my immunizations will be released to the New York Citywide Immunization Registry (CIR).

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to patient, if other than recipient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date/ Time Print: Interpreter's Name and Relationship to Patient

Last, First Name: _____ **DOB:** _____

Area Below to be Completed by Vaccinator				
Which vaccine is the patient receiving today?				
Vaccine Name	Administration		EUA Fact Sheet Date	Lot Number
Pfizer/ BioNTech	☐ First Dose	☐ Second Dose		
Moderna	☐ First Dose	☐ Second Dose		
Astra-Zeneca	☐ First Dose	☐ Second Dose		
Janssen	☐ Single Dose			

Administration Site: ☐ Left Deltoid ☐ Right Deltoid

Dosage: ☐ 0.3 mL ☐ 0.5 mL

☐ I have reviewed side effects with patient (and parent, guardian, or surrogate, as applicable)

☐ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Vaccinator Signature: _____

CONSENT FORM 同意書

Privacy Act Statement-The information contained on this form contains confidential patient information that is legally protected by the privacy Act of 1974, 5 U.S.C. 522, and the Health Insurance Portability and Accountability Act of 1996, P.L. 104-109 and other applicable federal and state laws. A photocopy of this assignment is considered as valid as the original. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
我們的“隱私保護通知”告訴您關于我們如何使用和透露您受保護的醫療信息。根據法律規定，該“通知”詳述病人的權利。在簽署之前，你有權審查這份同意書。同意書上的條款可能會改變。一旦改變，你可以通過聯繫我們的辦公室以取得修訂的副本。

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
您有權提出要求或限制我們如何使用或透露您受保護的醫療信息、付款或醫療保健業務。但我們不必同意此要求或限制。一旦我們這樣做，我們將履行該協議。

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
通過簽署本頁，您將同意我們使用和透露您受保護的醫療信息、付款和醫療保健業務。你有權撤回此書面同意，然而，這種撤回將不會影響任何您先前訂下的書面同意。醫療者可能提供此同意書至“健康保險轉移與責任法” (HIPAA)。

The patient understands that:
病人需了解:

- Protected health information may be disclosed or used for treatment, payment, or health care operations;
  受保護的健康信息可能會被透露，或用於治療、付款或醫療保健業務;
- The Practice has a Notice of Privacy and that the patient has the opportunity to review this Notice;
  醫療者擁有此“隱私通知”，而病人有權審查此通知;
- The Practice reserves the right to change the Notice of Privacy Practices;
  醫療者保留修改此“隱私通知”的權利;
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions;
  病人有權提出要求或限制我們如何使用其信息，但醫療者不必同意此要求或限制;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
  病人可于任何時間以書面形式撤銷此項同意及未來所有的信息披露，然後將停止。

This Consent was signed by: _____ _____

Printed Name 名字正楷 Signature 簽名

_____ _____

Relationship to Patient 與病人關係 Date 今天日期

Witness 見證人: _____ _____

Print Name – Practice Representative Date 今天日期