COVID Immunization Consent Form

Name (as it appears on insurance card): _____ Date of Birth: _____ Age: ____ Gender: Male / Female

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email Address: _____@_____ Phone Number: _____

Please contact me about screenings, immunization clinics and other promotions.

Race: ☐White ☐Hispanic/Latino ☐Black/African American

☐Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐Other

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

If you answer "YES" you may not be able to receive the COVID-19 vaccine.

Section 1: **If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to www.modernatx.com or call 1-866-MODERNA.*	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, date?		
Have you had any vaccines within the previous 14 days? Pfizer-BioNTech or Moderna COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? (including Pfizer-BioNTech or Moderna COVID-19 vaccine) Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive Pfizer- BioNTech or Moderna COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive Pfizer-BioNTech or Moderna COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-BioNTech or Moderna COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		

***NOTE:** Depending on vaccine type, a second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.*

Section 2: RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website https://www.fda.gov/media/144638/download or (modernatx.com)**
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

*My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).*

Signature of patient or guardian X:_____ Date:_____

Below is for pharmacy documentation

Ultra-cold COVID-19 Vaccine ☐ Pfizer-BioNTech	**1st Dose:** _____ **2nd Dose:** _____ **Frozen COVID-Vaccine** ☐ Moderna	**Refrigerated COVID-19 Vaccine** ☐ AstraZeneca ☐ Janssen ☐ Novavax-Matrix-M1 ☐ Other COVID-19 Vaccine _____		
Route ☐ IM	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number:**	**Expiration Date:**
MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck **Site Codes:** Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA					

Administered by: _____ Title: _____ Date Given:_____

Pharmacist Immunization Program
Improving Arkansas wellness

PATIENT REGISTRATION FORM

LAST NAME: _____
FIRST NAME: _____
PREFERRED NAME: _____
MIDDLE NAME, SUFFIX: _____
PREVIOUS NAME: LAST: _____, FIRST _____
SEX: _____ MALE _____ FEMALE
DATE OF BIRTH: MM _____ DD _____ YYYY _____
SOCIAL SECURITY NUMBER: _____
ADDRESS: _____
ADDRESS: _____
ZIP CODE: _____
CITY: _____
STATE: _____

HOME PHONE: _____ MOBILE PHONE: _____
CONSENT TO TEXT: _____ YES _____ NO WORK PHONE: _____
PREFERRED PHARMACY: _____
PRIMARY INSURANCE: _____
INSURANCE ID # _____ GROUP # _____
POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____
EMAIL: _____
CONTACT PREFERENCE: ____ HOME PHONE ____ MOBILE PHONE ____ WORK PHONE

LANGUAGE: ____ ENGLISH _____ SPANISH _____ OTHER

RACE: ___ BLACK OR AFRICAN AMERICAN ___ AMERICAN INDIAN OR ALASKA NATIVE
___ WHITE ___ ASIAN ___ NATIVE HAWAIIAN ___ OTHER ___ DECLINED

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___ OTHER ___ DECLINED

MARITAL STATUS: ___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED ___ PARTNER

GUARDIAN: LAST NAME: _____
FIRST NAME: _____
MIDDLE NAME, SUFFIX _____

EMERGENCY CONTACT: NAME _____
RELATIONSHIP: ___ SPOUSE ___ PARENT ___ CHILD ___ SIBLING
___ FRIEND ___ COUSIN ___ GUARDIAN ___ OTHER
HOME PHONE: _____
MOBILE PHONE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any information concerning me or my child's healthcare, advice or treatment used for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Doctor.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE

HEALTHSTAR PHYSICIANS

"DEDICATED TO QUALITY HEALTHCARE"

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I, _____, have received a copy of
(PLEASE PRINT YOUR NAME ABOVE)
The HealthStar Physicians of Hot Springs Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

FOR OFFICE USE ONLY

PATIENT WAS OFFERED THE HIPAA PRIVACY NOTICE:

_____ Refused _____ Accepted

Patient Account Number: _____ Employee's Initials: _____

Notes: _____

HealthStar Physicians of Hot Springs

1661 Airport Rd, Suite D
Hot Springs, AR 71913
Phone: 501-625-7500

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided upon your request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service, unless prior arrangements have been made. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

HealthStar
PHYSICIANS OF HOT SPRINGS

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, all services, including medication refills, will be discontinued for you and your immediate family, and your account will be turned over to a collection agency.

8. **No Insurance/Self Pay.** Please note that if you do not have insurance or have a large deductible not met when you come to the clinic, **payment is due at the time of service**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

My signature below confirms that I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

My signature below confirms that I have received and read a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Signature of patient or responsible party **Date**