REGISTRATION, ACKNOWLEDGEMENT & CONSENT FORM

Saint Alphonsus
A Member of Trinity Health

Please complete and bring with you to your appointment.

Date: _____

Patient Name (last, first, middle): _____

Birth Date: _____ Gender: □ M □ F □ Nonbinary □ Prefer not to answer Marital Status: □ S □ M □ D □ W

Race (select one): □ White □ Black or African American □ American Indian/Alaskan □ Asian

□ Unknown □ Native Hawaiian □ Other Pacific Islander □ Decline to answer

Ethnicity (select one): □ Not Hispanic/Latino □ Hispanic/Latino □ Unknown □ Decline to answer

Social Security Number _____ -_____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: (home/cell)_____ Secondary #: (home/cell)_____+_____

Patient Email Address_____

Emergency Contact (last, first, middle): _____Relationship:_____

Primary Phone # _____ Secondary Phone # _____

Employer: _____ Occupation: _____

Employer's Phone # _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Effective Date: _____ Policy Number: _____

Group Number: _____ Policyholder's Full Legal Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: □ M □ F □ Nonbinary □Prefer not to answer Birth Date: _____ Social Security _____-_____-_____

Secondary Insurance Co: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policyholder's Full Legal Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: □M □F □ Nonbinary □ Unknown Birth Date: _____ Social Security _____-_____-_____

Relationship to Patient: _____ Policyholder's Employer: _____

Patient Name: _____ Birth Date: _____

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 allergies to <u>any contents</u> in this vaccine, which includes polyethylene glycol (PEG) **OR** to polysorbate?	◯	◯	◯
3. Have you ever had any allergic reaction (severe or immediate) to any vaccine, including mRNA COVID-19?	◯	◯	◯
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? (For healthcare personnel: have you had a high risk exposure for which you have been recommended to quarantine?)	◯	◯	◯
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. Do you or have you had multisystem inflammatory syndrome (MIS)?	◯	◯	◯

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.

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 Saint Alphonsus Health System 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 Saint Alphonsus Health System, 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 Saint Alphonsus Health System 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 Saint Alphonsus Health System 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. Saint Alphonsus Health System 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: _____

*******PFIZER VACCINE ONLY*******

PATIENTS WHO ARE 5 - 17 YEARS OF AGE

I consent for Saint Alphonsus Health System to provide the Pfizer 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: _____

< < < < < < < TO BE COMPLETED BY PROVIDER > > > > > >> > > >	
IIS Additional Data Elements Required to be reported to the CDC	
Administered at location (facility name/ID)	Administered at location (type):
Administration Address (including county)	Administration Date:
CVX (Product)	Dose Number
Lot number: unity of use and/or unit of sale	MVX (manufacturer)
Sending Organization	Vaccine administering provider suffix
Vaccine administering site (on the body)	Vaccine Expiration Date
Vaccine route of administration	Vaccine series complete
IIS recipient ID	IIS vaccination event ID

VACCINE CODING INFORMATION (select one)

Manufacturer	Vaccine/ Immunization Product Code	Vaccine/ Immunization Admin Code
Pfizer – for ages 12 and older ◯	91300*	0001A (1st dose) ◯ 0002A (2nd dose) ◯
Pfizer – for ages 5-11 ◯	91307*	0071A (1st dose) ◯ 0072A (2nd dose) ◯
Moderna ◯	91301*	0011A (1st dose) ◯ 0012A (2nd dose) ◯