Vina Pharmacy COVID-19 Vaccination Consent Form

Section 1: Patient Information

Name: _____ Date of Birth: ___/___/_____ Phone: (_____)_____
Address: _____ City: _____ County: _____ Zip: _____
Social Security Number: _____-____-_____ (this is needed by the federal government in case you do not have insurance)
Race: __American Indian or Alaska Native __Asian __Black or African American
__Native Hawaiian or Other Pacific Islander __White __Other
Gender: ___Male___Female Ethnicity: __Hispanic __Non-Hispanic __Prefer not to disclose ___Other
Primary Care Provider Name: _____ Phone: (____)_____

Section 2: Screening Questions

1. Do you currently have COVID-19 or have you had it in the last 90 days? __Yes __No
2. Are you currently in quarantine for COVID-19 exposure? __Yes __No
3. Are you currently sick? (fever, chills, shortness of breath, aches, loss of taste or smell) __Yes __No
4. Have you ever had a severe reaction to a vaccine? __Yes __No
5. Have you had a vaccine in the past 14 days or are you scheduled to receive a vaccine in the next 14 days? __Yes __No
6. Are you pregnant or breastfeeding? __Yes __No
7. Are you immunocompromised or taking medications that affect your immune system? __Yes __No
8. Are you taking blood thinners or do you have a bleeding disorder? __Yes __No
9. Have you received plasma or antibody infusions for COVID-19 in the past 90 days? __Yes __No
10. Have you received the COVID-19 vaccine somewhere else? __Yes __No

Section 3: Consent for Vaccination

I hereby consent to Vina Pharmacy to administer the vaccine I have requested below. I understand that any protected health information will only be used in accordance with HIPAA Privacy Practices. I consent to the reporting of my immunization information to the Texas Immunization Registry, and I understand that this information will be accessible by other health care providers, educators, public health representatives, state agencies, and certain insurance payers. I authorize Vina Pharmacy to release my medical or other information to my healthcare professionals, Medicare, Medicaid, or third-party payer as necessary to effectuate care or payment or otherwise, submit a claim to my insurer for the below requested items and services, and request payment of authorized benefits be made on my behalf to Vina Pharmacy with respect to the below requested items or services. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with novel vaccines and elect to receive a COVID-19 vaccine. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for 15 minutes after administration for observation by the health care provider.

I hereby WAIVE, RELEASE and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) Vina Pharmacy, its staff, agents, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of COVID-19 vaccines and related services. I have received the Emergency Use Authorization Fact Sheet for the vaccines I have elected to receive.

Patient's or Guardian's Signature: _____ Date:_____
Relationship to Patient (if minor): _____

Section 4: Medicare Part B Use Only

Medicare Part B Authorization Statement to Permit Assignment of Medicare Benefits I understand that I am giving Vina Pharmacy permission to ask for Medicare payments for my medical care, including supplies and equipment. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a photocopy of this release is as valid as the original document. I understand that I am responsible for paying any deductible or coinsurance. Therefore, I ask that payment of authorized Medicare benefits be made either to me or on my behalf to Vina Pharmacy for services or items furnished to me by Vina Pharmacy. I authorize any holder of medical or other information about me to release such information to CMS and its agents as needed to determine these benefits or benefits for related services.

Name:_____ Medicare ID Number:_____
Signature:_____ Date:_____

Section 5: Pharmacy Use Only

Vaccine	Dose	Manufacturer	Route	Lot #	Site of administration
COVID-19	0.5 mL	Pfizer	IM		___RD __LD

Vaccinator's Name:_____ Vaccinator's Signature:_____ Date:_____