Clear Form

Side 1 of 2 to be completed

COVID Vaccine Intake Consent Form

CVS pharmacy

Clinic Information

CI135584	MAPLE CREST OF MENNONITE MEMORIAL H-CLINIC 1A		419-358-1015	
Clinic ID	Clinic Name		Telephone	Store Number
700 Maple Crest Ct.		Bluffton	OH	45817
Address		City	State	Zip

Patient Information

Last Name	First Name		Date of Birth	Gender
Address	City	State	Zip	SSN* (or driver's license)
Primary Care Provider (PCP) Name	PCP Phone Number		PCP Fax Number	
PCP Address	City		State	Zip

SSN and state of residence, or state identification/driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification/driver's license is not submitted, you will need to attest that you attempted to capture this information before submitting a claim and the patient did not have this information at the time of service, or that you did not have direct contact with the patient and thus did not have an opportunity to attempt to capture this information. 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

Insurance Information: Fill in all that apply

Prescription Insurance:

○ Patient is primary card holder (check box if yes)

Pharmacy Insurance Provider	ID #	GRP ID	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 A/B ID Number (MBI)

Medical Insurance:

○ Yes ○ No

Medical Insurance Provider	ID #	GRP ID	Is the patient the Primary Cardholder?

If you are uninsured, please read the below statement and check the box for acknowledgement:

○ I do not have medical insurance, Medicare, Medicaid or any commercial or government-funded health benefit plan I acknowledge that I must answer this question truthfully in order to have the cost of my test covered by the U.S. Department of Health and Human Services (HHS) Uninsured Program. If I have active insurance that I fail to provide, I may be charged in full for the vaccine.

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?	○	○	○
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	○	○	○
3. Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	○	○	○

To be filled out by the immunizer: Patient Temperature: | Date:

If patient answers yes to any of these questions or patient's bodily temperature is 100˚F or greater, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for next steps and that the facility coordinator will be notified.

Immunization Screening Questions	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	○	○	○
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)	○	○	○
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	○	○	○

Last Name | First Name | Date of Birth

Immunization Screening Questions (continued)

	YES	NO	DON'T KNOW
4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	○	○	○
5. Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner.	○	○	○
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?	○	○	○
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	○	○	○
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?	○	○	○
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?	○	○	○
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?	○	○	○
11. Have you received any vaccinations or TB skin test in the past 4 weeks?	○	○	○

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. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS Pharmacy® ("CVS®") 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 CVS® 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 at CVS (if applicable), 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 CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). State of California only: I agree to have CAIR share my immunization data with Health Care Providers, agencies or schools. 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

○ L ○ R

Administration Date | Vaccine | VIS Date | Manufacturer

Lot # | Exp. Date | Route | Site | Volume (mL)

Administering Immunizer Name & Title | Administering Immunizer Signature

To be filled out by immunizer, as required for state immunization registry reporting. Only for states listed.

MS: Check all fields for patients 18 years of age and younger
OK: Check Race and Ethnicity for all patients. Select Next of Kin for patients 18 years of age and younger.

Race: ○ **1** - American Indian or Alaska Native ○ **2** - Asian ○ **3** - Native Hawaiian/Other Pacific Islander ○ **4** - Black or African American ○ **5** - White ○ **6** - Other Race

Ethnicity: ○ **1** - Hispanic ○ **2** - Not Hispanic or Latino ○ **3** - Unknown

Next of Kin (18 or younger)

Name | Phone Number | Relationship

Address

State of NJ only

Prescriber Name | Prescriber Address

For CA, MA, MT, NJ, NM, NY, TX (For CA, this indicator means the registry will not share with Universities, Schools or other agencies)

Registry Sharing Indicator: ○ Yes ○ No