Franklin-Williamson Bi-County Health Department COVID-19 Vaccination Form

MODERNA COVID-19 VACCINE AGES 18 years and UP

Name ______________________________________ Birth date ______________
LAST FIRST M.I.

Address ______________________________ City ______________________

Phone ______________________________ Physician ______________________

Gender ☐ Male ☐ Female

Age Group ☐ 18 years – 64 years ☐ 65 years and over

Circle appropriate answers

1. Have you had a fever of 100 degrees or greater during the last 24 hours? .... YES NO
2. Are you allergic to **EGGS, LATEX** or any medications causing swelling of the mouth or throat, difficulty in breathing or shock? .... YES NO
3. Have you ever had a severe reaction to a previous immunization such as a fever over 105 degrees, paralysis, convulsions, total collapse or shock, or a severe itching rash? .... YES NO
4. Are you pregnant, planning to become pregnant or breast feeding?.......................................YES NO
5. Have you received another COVID-19 vaccine?...YES NO
   *If yes, which product ______________________________
6. Are you immunocompromised or are on medicine that affects you immune system?................ YES NO
7. Do you have a bleeding disorder or are on blood thinner?.. YES NO
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?...YES NO
9. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?.. YES NO
10. Have you had a vaccine in the past 14 days or are you planning to receive a vaccine in the upcoming 14 day time period?.. YES NO

CONSENT AND AUTHORIZATION:

I have read or had explained to me the Emergency Use Authorization for MODERNA COVID-19 Vaccine To Prevent Coronavirus Disease 2019 and understand the risks and benefits. I GIVE CONSENT to FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT to vaccinate the person listed at the top of this form with MODERNA COVID-19 Vaccine, per EUA from the FDA.I have received information regarding HIPAA. I give consent for my information to be entered into the ICARE database. I authorize the release of any information necessary to process a Medicare, Medicaid or Insurance claim if applicable. I request payment of benefits to Franklin-Williamson Bi-County Health Department.

SIGNATURE of client/parent/or legal guardian ______________________________

FWBCHD Office Use Only

☐ **MODERNA COVID-19 VACCINE** **Lot # 026L20A** **Exp. Date 6/28/21**

☐ **FACT SHEET FOR RECIPENTS AND CAREGIVERS/EMERGENCY USE AUTHORIZATION (EUA) of THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE (COVID-19) IN INDIVIDUALS 18 YEARS and OLDER AS BEEN GIVEN TO PATIENT.**

☐ ***Left Deltoid*** ☐ ***Right Deltoid***

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☐ *Marion* ☐ *Benton* ☐ *H/H* ☐ *Homebound* ☐ *Facility* ______________________

Signature of Nurse Administering Vaccine(s): ______________________ *Date* __________

Time __________

COVID-19 STATE SUPPLYINSURANCE INFORMATATION COLLECTED FOR ADMIN FEE** ☐

White rev12/21/2020

FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT
Patient Registration Form

PATIENT INFORMATION

Patient Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone Number: **Cell:** ______________ **Consent to Call** **Yes** ☐ **No** ☐

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Gender:** ☐ **Male** ☐ **Female**

DATE OF BIRTH: ___/___/___ **Email Address:** ______________ ☐ **Opt out of Email Communications**

Primary Care Physician: ____________________

RESPONSIBLE PARTY INFORMATION (Information Used for Patient Billing Statements)

☐ **Check Here if Same As Patient**

Name of Responsible Party: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone Number: **Cell:** ______________ **DATE OF BIRTH:** ___/___/___

Relationship to Patient: ____________________

INSURANCE INFORMATION:

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Ins. Co Name	Ins. Co Name
Policy Holder Name / Date of Birth	Policy Holder Name / Date of Birth
Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder
Policy ID	Policy ID

PAYMENT INFORMATION: INITIAL

________ **Bill my insurance company. I authorize my insurance company to pay benefits directly to FWBCHD.**

FINANCIAL RESPONSIBILITY: ___________ **INITIAL**

I understand that I am financially responsible for all charges for services rendered by Franklin-Williamson Bi-County Health Department. I understand all co-pays and deductibles due are my responsibility. I further understand that if my insurance company has not paid within 90 days, I am responsible for the full amount due Franklin-Williamson Bi-County Health Department. If it becomes necessary for the account to be transferred to a collection agency for collection, I agree to pay all costs of collection including attorney fees.

I certify:

1. That I have read or have had this consent read to me;
2. That I was given an opportunity to ask questions;
3. That all questions were answered to my satisfaction; and,
4. That I understand this consent and accept its terms and conditions

______________________________ ______________
Signature of Patient (or Parent/Legal Guardian) Date

______________________________ ______________
Printed Name of Patient (or Parent/Legal Guardian) Relationship to Patient

____
Witness

Williamson County Office:
8160 Express Drive
Marion, IL 62959-9808
Phone 618/993-8111
Fax 618/993-6455

www.bicountyhealth.org

Franklin County Office:
403 East Park
Benton, IL 62812-1920
Phone 618/439-0951
Fax 618/438-3005

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Health Department reserves the right to change the privacy policy as allowed by law.
- The Health Department has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Health Department may condition receipt of treatment upon execution of this consent.

____(PRINT CLIENT NAME)

This consent was signed by:______________________________________(PRINT NAME PLEASE)

Signature of Client/ Guardian:____Date:__________

Witness:____ Date:____________________