COVID-19 Vaccination Intake Form

GRIFFIN HEALTH

Patient Name: _____

Gender: _____ **Date of Birth:** _____ **Social Security Number:** _____

Address: _____ **Age:** _____

City: _____ **State:** _____ **Zip code:** _____

Email: _____

Phone Number: _____

Responsible Person: _____ **Relationship to Patient:** _____

Race: **Asian** **American Indian / Alaska Native** **Hawaiian / Pacific Islander**

Black / African American **White** **Other**

Ethnicity: **Hispanic / Latino** **Not Hispanic / Latino** **Unknown / Not Reported**

Additional Helpful Information

Name of Primary Insurance: _____ **Insurance ID Number:** _____

Subscriber Name: _____

Subscriber DOB: _____ **Subscriber Relationship to Patient:** _____

OFFICE USE ONLY					
ADULT		**PEDIATRIC**			
VACCINATOR FULL NAME:		**VACCINATOR FULL NAME:**			
12+	**12+**	**INFANT**	**INFANT**	**PEDIATRIC**	**PEDIATRIC**
PFIZER	MODERNA	PFIZER	MODERNA	PFIZER	MODERNA
BIVALENT 1st ☐	BIVALENT 1st ☐	BIVALENT 1st ☐	BIVALENT 1st ☐	BIVALENT 1st ☐	BIVALENT 1st
BIVALENT 2nd (65+) ☐	BIVALENT 2nd (65+) ☐	BIVALENT 2nd ☐	BIVALENT 2nd ☐		
		BIVALENT 3rd ☐	BIVALENT 3rd ☐		
		BIVALENT 4th ☐			
DATE:		**DATE:**			
LOT NUMBER:		**LOT NUMBER:**			
INJECTION SITE:		**INJECTION SITE:**			
SUPPORT NAME:		**SUPPORT NAME:**			

LEAD CHECK _____ **SHELTON** ☐

VERIFIED IN CTWIZ _____ **MOBILE** ☐

LOCATION _____

Patient Acknowledgement and Attestation Form for COVID-19 Vaccination

GRIFFIN HEALTH

I understand and agree to the following as part of my receiving the COVID-19 vaccine from Griffin Hospital:

- There is no co-payment or out-of-pocket expense to me.
- Griffin Hospital has received the vaccine at no cost and will not submit any bills or invoices seeking payment for the cost of the vaccine.
- I agree and consent to receive the COVID-19 vaccine and acknowledge that the risks, benefits, and alternatives have been explained to my satisfaction. I understand the COVID-19 vaccine has the potential side effects. I understand there is a remote risk of more severe or unexpected side effects. I understand that the emergency use of the COVID-19 vaccine has been authorized by the United States Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA).
- I permit Griffin Hospital to obtain payment for administering the vaccine to me. I understand and agree to the following provisions:

  Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided, and healthcare operations.

  Release to insurer: I understand that Griffin Hospital and/or any physician entity, or organization providing medical services and may release information to my insurance carrier(s) to substantiate payment for medical care or services, or employers (and/or their insurance carriers) in Workers' Compensation matters. Such persons or entities are permitted to examine and obtain necessary information from my medical records in accordance with application law related to patients' confidential health information and the Medical Records policies of Griffin Hospital.

  Assignment of benefits: I assign to Griffin Hospital and/or any physician, entity, or organization providing medical services to me any and all benefits, including payment, to which I may be entitled. Payments include those from any government agency, insurance carrier, or others financially responsible for the medical care rendered to me or my dependent.

  Appeal: I agree that Griffin Hospital may appeal any disallowance of payment by my insurance company for medical care rendered.

  Provisions specific to Individuals with Medicare Insurance: I certify that the information I have provided for purposes of applying for payment under Title XVIII of the Social Security Act is accurate. I understand that any holder of my medical or other information regarding my treatment may release to the Social Security Administration and/or the Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any necessary information needed in relation to a Medicare claim. In relation to a Medicare claim, I request that payment of authorized benefits be made on my behalf. I assign the Medicare benefits payable for physician services to the physician, entity, or organization furnishing the services or authorize such physician, entity, or organization to submit a claim to Medicare on my behalf.

Attestation: By signing this form I attest that I meet the State of Connecticut vaccination eligibility requirements.

Patient Signature or Responsible Person Date/Time

Responsible Person's relationship to patient (if applicable)