MERCYONE

REGISTRATION, ACKNOWLEDGEMENT & CONSENT FORM
Child & Teen COVID-19 Vaccination (Pfizer)

This form needs to be completed, signed electronically, and emailed to Margaret Peterson at MercyOne New Hampton at Margaret.peterson@mercyhealth.com. Please email the completed form 7 days prior to the appointment so the patient can be pre-registered, which will speed up the check-in process when you arrive for the appointment. If you have any questions, please call 641-394-1688.

Date: ______________________________

Patient Name (last, first, middle): ____

Birth Date:________________ Sex: □ M □ F □ Nonbinary □ Unknown

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 (or guardian) Email Address____

Emergency Contact (last, first, middle):___________________________Relationship:_______________________

Primary Phone # __________________________Secondary Phone # ___________________

INSURANCE INFORMATION

Primary 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:_____________________________

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 any allergies to any contents in this vaccine?			
3. Have you ever had a severe allergic/ anaphylactic reaction to any vaccine?			
4. Do you have a bleeding disorder or are you on a blood thinner?			
5. Are you immunocompromised or on any medications that effect your immune system?			
6. Have you received a COVID-19 vaccine previously?			
7. In the past two weeks, have you tested positive for COVID-19 or have you currently been exposed to someone with COVID-19?			
8. 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?			

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.

If patient is under the age of 18: I understand a parent and/or guardian will need to be present at the time of vaccination and wait with the child for 15 minutes after the vaccination.

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 MercyOne 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 MercyOne, 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 MercyOne 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 MercyOne 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. MercyOne 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:** ____________

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<< < < < < < 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

Manufacturer	Vaccine/ Immunization Product Code	Vaccine/ Immunization Admin Code
Pfizer	91300*	0001A (1st dose) 0002A (2nd dose)