CarePoint
Rheumatology and
Specialty Infusion Center

23215 Commerce Park, Suite 318
Beachwood, OH 44122
P: (216) 755-4044 | F: (330) 967-0571

COVID-19 IMMUNIZATION CONSENT

Name: _____ Date of Birth: _____ Sex: ☐ F ☐ M

Street Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Race: _____ Ethnicity: _____

***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 for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

CONSENT:

I hereby give my consent for the physicians and staff of CarePoint Infusion Center to examine, give medical care/treatment and perform diagnostic therapeutic procedures and to administer such medications/vaccines as may be necessary and appropriate to the patient named above. If receiving immunizations, I have been provided a copy of and have read the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of The Moderna, Pfizer, or Johnson and Johnson COVID-19 Vaccine to Prevent Coronavirus Disease 2019 in Individuals 18 Years of Age and Older for the Moderna, Pfizer, or Johnson and Johnson COVID-19 vaccine. The immunization dates will be sent to the Ohio Department of Health and entered in the state vaccine registry. I have received and reviewed the Notice of Privacy Practices and understand that these explain how the medical information of the patient may be used and disclosed. I acknowledge that this consent is voluntary and I may revoke the consent orally, in writing to the CarePoint Infusion Center at 23215 Commerce Park Suite 318, Beachwood, OH 44122, or by emailing wecare@carepointinfusion.com. I authorize the release of any information concerning my (or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. We may disclose health information to doctors or hospitals that are treating you. We may also use your health information to arrange certain services for you or to refer you to another program. If payment is required, I also hereby authorize payment of insurance benefits otherwise payable to me directly to CarePoint Infusion Center.

_____	_____	_____
Name (Relationship to Patient)	Signature of Patient (or Patient Representative)	Date

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Pre-Vaccination Checklist

Pre Vaccination Checklist	No	Yes	Unknown
Are you feeling sick today?			
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product?			
Have you ever had an allergic reaction that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital.			
Have you received another vaccine in the last 14 days?			
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
For women, are you currently pregnant, plan to become pregnant or breastfeeding?			
Do you have dermal fillers?			

FOR OFFICIAL USE

Vaccine Manufacturer: _____ Lot #: _____ Exp. Date: _____

Site of Injection (Deltoid): ☐ Right; ☐ Left

Administered By (Full name and Title): _____ Date of Vaccine: _____

ICD-10: Z23 Admin Codes: CPT code: