BREWSTER AMBULANCE SERVICE

DATE of VACCINATION: _____

LOCATION of VACCINATION: _____

COVID-19 VACCINE SCREENING and CONSENT FORM

FIRST NAME: _____ LAST NAME: _____

MIDDLE NAME: _____ Date of Birth: _____

ADDRESS: _____ STATE: _____

CITY: _____ ZIP: _____

PHONE: _____

Insurance (Circle One): Medicare MassHealth Private Uninsured

(Please do not use Medicare Supplements as they will not cover the injection, Please use your Medicare A or B)

If Private Insurance please enter the insurance name: _____

Member Number: _____ Group Number: _____

DOSE #: 1ST DOSE 2ND DOSE

RACE:
White
Black- African American
Asian
Pacific Island
Hawaiian
American Indian
Alaska Native

GENDER
Male
Female
Not reporting / Other

ETHNICITY:
Non-Hispanic
Hispanic
Unknown

FOR ADMINISTRATIVE USE ONLY:

Vaccine		Route	Site	Date Dose Administered
COVID-19	0.5 mL 0.3mL	IM	R- Deltoid L- Deltoid	
Vaccine trade name/Manufacturer		**Lot Number**	**Expiration Date**	**Name & Title of Vaccine Administrator**

SCREENING for COVID-19 VACCINE ELIGIBILITY

Please circle **YES** or **NO** for each question

Is the recipient under 18 years of age? If you answer YES, then a Parent or Guardian must sign below.	**YES**	**NO**
Has the recipient received any vaccinations within the last **14** days?	**YES**	**NO**
Has the recipient received a previous dose of COVID-19 vaccine?	**YES**	**NO**
Does the recipient have a known allergy to an ingredient of the COVID19 vaccine, or any other vaccine, or has the recipient experienced an anaphylactic allergic reaction to other injectable medications?	**YES**	**NO**
Is the recipient currently pregnant or breastfeeding?	**YES**	**NO**
Does the recipient currently have any symptoms of COVID-19?	**YES**	**NO**
Did the recipient have a confirmed case of COVID-19 **≤90** days ago?	**YES**	**NO**
Has the recipient received monoclonal antibody or convalescent serum for COVID-19 **≤90** days ago?	**YES**	**NO**
Does the recipient take blood thinners, or have a known bleeding disorder?	**YES**	**NO**
Does the recipient have a weakened immune system caused by something such as HIV infection or cancer, or does the recipient currently take immunosuppressant drugs or therapies?	**YES**	**NO**

IF ANY QUESTION LISTED ABOVE IS ANSWERED YES, PLEASE REFER TO THE ONSITE STAFF FOR CLARIFICATION

CONSENT for VACCINE ADMINISTRATION and BILLING:

I have been provided with the Emergency Use Authorization (EUA) for COVID-19 Vaccine Information Sheet. I have read or have had explained to me the information provided about the COVID-19 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. I voluntarily consent to administration of the COVID-19 vaccine and assume the risk for any reactions that may result. **I agree to stay in the building for 15 minutes (30 minutes if I have a history of an anaphylactic allergic reaction to any vaccine or injectable medication**. I understand I may experience soreness or swelling at the injection site, fever or generally not feel well for 24-48 hours. If symptoms become severe, I will contact my primary care provider or seek emergency care.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Brewster Ambulance Service** now, in the past, or in the future, until such time as I revoke this authorization in writing. I agree to immediately remit to the ambulance service any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to the ambulance service. I authorize the ambulance service to appeal payment denials or other adverse decisions on my behalf.

I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to the aforementioned ambulance service and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by the ambulance service, now, in the past, or in the future. I also authorize the aforementioned to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

The patient must sign here unless the patient is physically or mentally incapable of signing.

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

DATE:_____ SIGNATURE:_____ PRINT NAME:_____

☐ **I am not insured by Health Insurance, by checking this box and signing below, I attest that I am uninsured.**

DATE:_____ SIGNATURE:_____ PRINT NAME:_____

AUTHORIZED REPRESENTATIVE SIGNATURE Complete this section **only** if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Brewster Ambulance Service** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- Patient's legal parent or guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the patient

DATE: _____ SIGNATURE: _____ PRINT NAME _____