ADLER'S PHARMACY
100 Dobbs Lane; Suite 205
Cherry Hill, NJ 08034
(P) 856-685-7264 (F) 856-520-8464
adlersrx@gmail.com
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COVID-19 Vaccine Intake Consent Form

Section 1: Patient Information (Please Print)

Patient Name (Last)	(First)	M.I	Patient Date of Birth Month_____ Day_____ Year_____

Street Address	City	State	Zip Code	Home/Mobile Phone #

Primary Care Physician Name: (Last)	(First)	Street Address

City	State	Zip Code	Phone Number	Fax Number

Allergies:

Race: ◯ 1 - American Indian or Alaska Native ◯ 2 - Asian ◯ 3 - Native Hawaiian/Other Pacific Islander ◯ 4 - Black or African American ◯ 5 - White ◯ 6 - Other Race

Ethnicity: ◯ 1 - Hispanic ◯ 2 - Not Hispanic or Latino ◯ 3 - Unknown

Are you a **resident** ◯ or **employee** ◯ of a Long Term Care Facility? ◯ **N/A**

If yes: Name of Facility _____

Section 2: Insurance Information:

Prescription Insurance:

Are you the primary cardholder?
Yes ◯
No ◯ (**If No**, please include the primary cardholder's DOB, relationship and 0# found next to the Member ID on the insurance card)

Prescription Benefit Plan Name	Cardholder ID #	RX Group ID	BIN	PCN

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Medicare Fields:

◯ Yes ◯ No

Is the patient age 65 or older or Medicare eligible?	Medicare Part A/B ID Number (MBI) **Note:** *MBI is required for all patients Age 65 or older, or Medicare eligible. Refer to your Medicare Red, White, And Blue card*

Medical Insurance:

Medical Insurance Provider	Cardholder ID #	Group ID	Payer ID

◯ **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.

Social Security Number	**State Identification Number & State**	**Driver's License Number & State**

Section 3: Screening for Vaccine Eligibility

1. Has this patient been vaccinated with the Covid-19 vaccine? **Yes** ◯ **No** ◯

Vaccine Administration Information for Immunizer/Pharmacist use only

Vaccine Brand (Pfizer, Moderna, Astra Zeneca. Johnson and Johnson):_____

Date dose #1 given: *Month* _____ *Day* _____ *Year* _____

Date dose #2 (*if necc*) given: *Month* _____ *Day* _____ *Year* _____

Lot# _____ Site: RA [ ] LA [ ]

Exp. Date _____ Clinic: Yes [ ] No [ ]

Signature of pharmacist who administered the vaccine(s) and provided VIS to the patient _____

License # _____ NPI #_____ Date _____

Signature of Certified Immunizing Technician who administered the vaccine(s) _____

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Section 4: Consent

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the 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 and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Adler's Pharmacy LTC to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Adler's Pharmacy LTC 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 at my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Adler's Pharmacy LTC will use and disclose my health information as set forth in the Adler's Pharmacy LTC Notice of Privacy Practices (copy is available by requesting a paper copy from the pharmacy).

x_____

Signature of patient to receive vaccine (or authorized representative) **Date**

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient

Name of parent, guardian, or authorized representative Phone Number Relationship