Ephraim McDowell Regional Medical Center, Inc.

Informed Consent Form for SARS-CoV-2 (COVID-19) Immunization

Who is receiving the vaccine? (Please print)

_____ _____ ____ Gender: ◯ M ◯ F

Last Name First Name Middle Name Date of Birth (MM/DD/YYYY) Age

_____ _____ _____ _____ (_____)_____-_____

Home Address City State Zip Phone Number

_____ _____ (_____)_____-_____

Emergency Contact Name Relationship to Patient Phone Number

Do you have a Primary Care Provider? ◯Yes ◯No _____(_____)_____-_____

Primary Care Provider Name Primary Care Phone

Receiving today (Select one) O First Dose O Second Dose O Additional Dose (Immunocompromised or Booster Dose)

Date of last vaccination and manufacturer (Moderna, Pfizer, or J&J): _____

	Screening Questions: Please answer each question by marking either "yes" or "no". If you answer "yes" to any question please discuss your answer with the health care provider.	**Yes**	**No**
1	Are you feeling sick today or had a fever in the past 24 hours?		
2	Have you had COVID-19 in the past? Date:_____ ***(If Yes, answer question 2a)***		
2a	Have you been hospitalized due to COVID-19 Infection? Date:_____		
3	Do you have any allergies (e.g., medications, foods, or latex? If you mark "yes", please list all allergies: _____		
4	Have you ever had a serious reaction or fainted after receiving any vaccination or injection?		
5	Do you have a bleeding disorder or are you on a blood thinner?		
6	Are you allergic to any ingredient of this vaccine? (Ingredients are on the Vaccine Information Statement or Fact Sheet for Recipients and Caregivers.)		
7	Have you previously received a Covid-19 vaccine? ***(If Yes, answer question 7a)***		
7a	If you received a Covid-19 vaccine, did you have an allergic reaction to one or more dose(s)?		
8	Are you immune-compromised/Immunosuppressed or are you on medicine that affects your immune system? ***(If yes, answer question 8a)***		
8a	*This is your additional dose and you attest that you have one of the following conditions:* • *Active treatment for solid tumor and hematologic malignancies* • *Receipt of solid-organ transplant and taking immunosuppressive therapy* • *Receipt of CAR-T cell or hematopoietic stem cell transplant (within 2 years of transplant or on immunosuppressive therapy)* • *Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)* • *Advanced or untreated HIV infection* • Active treatment with high-dose corticosteroids (≥ *20mg prednisone ore equivalent per day)* or other drugs that suppress my immune response		
9	This is your booster dose and you attest that you meet one of the following criteria set by the CDC and ACIP? • 65 years or older, or Residents in long term care setting, or 18-64 years old with underlying medical condition described by the CDC guidance, or 18 years or older with increased exposure due to occupational or institutional exposure		

Have you completed all information on the other side of this document?

Informed Consent, Release, and Waiver: Please read and sign.

By my signature below, I consent to the administration of the vaccine for SARS-CoV-2, the virus that causes the Coronavirus Disease 2019 (COVID-19). I consent to be contacted at the number provided above regarding any other required dose of this vaccine for which I am due to receive. I understand, affirm, and acknowledge that:

1) I am of legal age and authorized to execute this consent form.
2) I voluntarily choose to receive the vaccination from Ephraim McDowell Regional Medical Center staff.
3) I acknowledge that the vaccine I am receiving is subject to Emergency Use Authorization (EUA) by the U.S. Food and Drug Administration (FDA), which permits the vaccine to be administered for emergency use when there are no adequate, approved, and available alternatives.
4) I have received, read, or have had read to me, the Vaccine Information Statement (VIS) or EUA Fact Sheet for Recipients and Caregivers provided for the vaccine to be administered.
5) In addition to my answers to the questions on this form, I will immediately alert the health care provider before receiving the vaccine of any medical conditions which may adversely affect my personal health or the effectiveness of the vaccine.
6) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I have also been counseled that there may be side effects or risks to the vaccine that are not identified in the VIS or Fact Sheet for Recipients and Caregivers and therefore unknown to the health care provider. I understand that I am responsible for following up with my primary care provider or other appropriate health care provider of my choice if I experience any side effects.
7) I understand the benefits and risks of the vaccine to the extent such benefits and risks are currently known.
8) I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
9) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation.
10) This vaccination may be subject to reporting to federal and state health oversight agencies and to my primary care provider, if applicable, and I authorize these disclosures.
11) **Release and Waiver**: I fully release and discharge Ephraim McDowell Regional Medical Center, Inc. and its parent corporation(s), subsidiaries, affiliated or sister entities, officers, directors, employees, volunteers, and agents from all liability, including acts of omission or commission, relating to, or arising from, my receipt of the vaccine and I knowingly and voluntarily waive any and all claims or causes of action I may have against them related to, or arising from, my receipt of the vaccine.

Signature of Patient: _____ Date: _____

FOR HEALTH CARE PROVIDER USE ONLY

To be completed <u>BEFORE</u> administering the vaccine:

1) I confirmed the patient's name, D/O/B, and age to match information on the form. Initial here: _____
2) I reviewed the Screening Questions with the patient. Initial here: _____
3) I have given and discussed the VIS or Fact Sheet for Recipients and Caregivers. Initial here: _____
4) This is the patient's **First Dose** ◯ **Second Dose** ◯ **Additional/Booster Dose** ◯ Initial here: _____
5) **If this is the patient's Second Dose/Additional/Booster Dose**, I have confirmed:
   a) All doses are of the same Covid-19 vaccine for first and/or second dose. Initial here: _____
   b) The patient's Last Dose was given on _____ (MM/DD/YYYY). Initial here: _____

To be completed <u>AFTER</u> administering the vaccine:

Medication:_____ Lot #:_____ Exp Date: _____ Site: ____ Laterality ____

Administered by: _____ Title: _____ Date Given:_____

Have you completed all information on the other side of this document?

Ephraim McDowell Health®

❖ Consent for Medical Care and Treatment

- I understand and acknowledge that this General Consent and Acknowledgment applies to services provided at:
  Ephraim McDowell Regional Medical Center

  Ephraim McDowell Fort Logan Hospital

  Ephraim McDowell James B. Haggin Hospital

  Ephraim McDowell Health Resource Clinics

  (The designated location is referred to herein as Ephraim McDowell Health "EMH" and includes Ephraim McDowell Regional Medical Center, Ephraim McDowell Fort Logan Hospital, Ephraim McDowell James B. Haggin Hospital, Ephraim McDowell Health Resource Clinics, and any outpatient departments and provider-based clinics, on or off the campus of the hospitals).

  I consent to the rendering of medical care and treatment, including routine diagnostic testing, considered necessary or advisable by EMH's physician and providers, including the administration of blood products. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location and I consent to such services. I consent and authorize EMH to engage in such tests as it deems necessary to determine if I have an infectious disease which might be harmful or unsafe to personnel or other patients. This may include testing for HIV (the virus that causes AIDS), Hepatitis, or any other blood borne infectious disease. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, test, or surgery performed at EMH.
- I understand that health care providers in training, including nursing, pharmacy, medical students and resident physicians, may be involved in my care and treatment and I consent to their involvement in my care.
- I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body.

❖ Patient Rights and Responsibilities

- I understand that I may have my picture taken at registration to verify my identity and secure my Protected Health Information ("PHI").
- I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint(s), to agree upon a treatment plan, and follow that plan.

❖ Notice of Drug and Medication Safety

- I understand that unauthorized drug or alcohol use (including illicit or illegal substances, unauthorized medications and alcohol) may significantly interfere with the treatment plan(s) as ordered by my physician(s) and other health care providers. I understand that use of illicit or illegal substances, unauthorized medications or alcohol during my admission or treatment can put me at risk for harm or adverse drug reactions, compromise prescribed medical treatment, cause permanent damage to my physical and/or mental functioning, or result in death.
- I acknowledge that the Drug, Alcohol and Medication Safety Notice ("Notice") has been made available to me and that I understand and agree to comply with the information provided therein, and knowingly and freely assume all such risks (both known and unknown) stated in the Notice.
- I acknowledge and agree that I am fully responsible for my actions and decisions if I engage in activities such as the use of illicit or illegal substances, unauthorized medications or alcohol during my admission or treatment at EMH. I agree to release, discharge, hold harmless, defend and indemnify Ephraim McDowell Health, Inc., as defined in this General Consent, including their directors, officers, employees, and health care providers and clinicians from any and all claims, lawsuits, actions, or losses which are caused in whole or in part by my use of illicit or illegal substances, unauthorized medications or alcohol during my admission or treatment at EMH.

❖ Use and Disclosure of Health Information

- I authorize EMH to record medical and other information related to my treatment in paper, electronic, photographic, video and other formats.
- I authorize EMH to use and release my medical and other information in the course of my treatment to all payers for processing health care claims, to accrediting and quality organizations, regulatory agencies, public health reporting agencies, to those persons designated by me as my billing addressee/guarantor for handling the billing, payment, and health care coverage for my account or other persons or entities for healthcare operations.
- I authorize EMH and its physicians and other health care professionals and providers to release my medical and other information with my other health care professionals and providers to facilitate treatment, discharge planning or payment.
- I understand and acknowledge that a copy of the Notice of Privacy Practices pamphlet has been made available to me. A copy is also available at https://www.emhealth.org/about-us/privacy-policy/. I understand that I can also request a paper copy during my visit at Hospital.

- A health information exchange ("HIE") allows my health care providers to electronically access my medical information held by other participating providers to provide me with better care. I authorize Hospital to access my health information that is available through a HIE and Hospital may also make my Hospital health information available through HIEs in which it participates. Unless I request otherwise, if admitted to EMH, I authorize EMH to provide my room location and telephone number to visitors if requested.
- As applicable, I specifically authorize the release by EMH of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to: 1) my treating physicians and other healthcare providers, and; 2) any private health insurance plan, Medicare, Medicaid, other governmental insurance program or other third-party payer identified to obtain payment for the treatment and services provided to me.

❖ Responsibility for Payment/Assignment of Benefits/Contact

- I acknowledge that I am responsible for all charges for services provided at EMH, including any amount not paid by my health care or other benefits plan(s), other than billing terms and restrictions under a government program. I authorize EMH to apply any credit balance on my account to any amounts that I may owe to one or more EMH entities. Information on financial assistance and/or payment options is available by calling 859-239-2342 or visiting https://www.emhealth.org/for-patients/going-home/billing-insurance/.
- I agree to pay EMH and any independent professionals involved in my care for all services and supplies provided to me. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs provide benefits for my treatment, I authorize EMH to bill any such payer for all charges incurred by me in connection with the services provided at EMH. I understand that EMH's efforts to bill any payer on my behalf is a courtesy to me and that EMH has the right, should it deem advisable, to demand payment in full from me at any time prior to full payment from any payer, unless EMH and the payer have agreed that I will not be billed. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by any benefits programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided at EMH. I also understand I will be billed for any charges not paid by my payer and I will be responsible for paying them. I understand and acknowledge that:
  - I am responsible for contacting my benefits provider, if any, to obtain authorization before services are rendered at EMH, and if I do not pre-certify for such services, if required, my benefits may be reduced or lost, and I will still be responsible for paying for the services at EMH. Any questions I have regarding my benefits coverage or levels should be directed to my payer. I understand that I will receive separate bills for the services provided to me by the employed and independent contractors involved in my care at EMH. The independent contractors involved in my care may not be participating providers in my benefits plan or network and I may have greater financial responsibility for their services at EMH if they are not under contract with my health plan.
  - If I elect to pay for medical treatment in full before services are provided, I can request that my health insurance or other payer, in any form, not be billed or notified that the services were provided. If I have not paid for my treatment in full before or at the time of services, I understand and acknowledge that EMH may disclose my health information to an identified insurer or other payer with whom I may have benefits for the purposes of obtaining payment.
- I assign to EMH, and any independent contractors involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or other programs identified for which benefits may be available to pay for the services provided to me at EMH. EMH and Independent Contractors may contact my payers to obtain pertinent financial information concerning coverage and payments made under any benefits plans applicable to me and my payers may release such information to EMH and Independent Contractors. I authorize payment for services at EMH to be made directly to EMH or the Independent Contractors. If my healthcare benefits plan will not allow direct payment to EMH or the Independent Contractors, I agree to immediately forward to EMH (or the Independent Contractor, if applicable) all health insurance payments I receive for the services performed at EMH. I authorize EMH's agents to act on my behalf to appeal any claims denied or paid in error by any healthcare payer. Any appeal by EMH is being provided as a courtesy to me and EMH may decide not to appeal such claims. Further, EMH may withdraw any appeal, at any time, and at its discretion.
- If I default or do not pay for treatment provided, I acknowledge and agree that EMH is entitled to recover the full amount of the debt owed for medical services and is entitled to the right of recovery of all collection expenses, including litigation or arbitration costs, and reasonable attorney's fees incurred for the purpose of securing payment. Collection expenses and/or attorney fees include the fee charged to EMH to complete the collection.
- I agree that in order for EMH to service my account or to collect any amounts I may owe, EMH or a vendor acting on its behalf, may contact me, as allowed under applicable laws, by telephone at any telephone number associated with my account, including cellular telephone numbers, which could result in charges to me. I agree that EMH or a vendor acting on its behalf may also contact me by sending text messages, which could result in charges to me, or by sending emails to any e-mail address I have provided to EMH. I acknowledge and agree that methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- If I am uninsured or am having difficulty paying my EMH bill, I understand EMH has many financial options that may be of assistance to me. I understand that I will be required to provide financial information to determine my eligibility for these programs. Further information can be obtained by contacting one of our financial counselors.

❖ Personal Property and Valuables

- I understand that my personal property is my responsibility and that EMH is not responsible for the loss, destruction or theft of my personal property. By signing below, I acknowledge that I have been advised to send all of my valuables home during an EMH inpatient stay. I am aware that there might be storage options available at EMH for use while I am an inpatient. I am aware that there are no storage options available for outpatient departments of EMH or provider-based clinics of the EMH. I assume full responsibility for my personal property, including but not limited to my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items and release EMH from any and all responsibility and liability for such personal items and valuables.

- I understand that illicit or illegal substances, unauthorized medications and alcohol are not considered personal property or valuables. These items cannot be stored or secured by EMH during your admission. I further understand and agree that illicit or illegal substances, unauthorized medications and alcohol will not be returned to me if I voluntarily surrender them or if they are removed from my possession while seeking treatment at EMH.

❖ **Acknowledgment That Independent Contractors Are Not Employees or Agents**

- I understand and acknowledge that independent contractors who are not employees of EMH may provide services to me at EMH. I consent to services being provided by such independent contractors. Such independent contractors are not employees or agents of EMH but are independent medical practitioners who have been permitted to use facilities for the care and treatment of patients. These professionals may include, but are not limited to, admitting and/or attending physicians, consulting physicians, on-call physicians, emergency room physicians, hospitalists, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, medical students, resident physicians, other specialists and allied health professionals employed by such providers. I understand that EMH does not control or direct the care of patients by independent contractors. I acknowledge that my decision to seek care at EMH is not based upon any understanding, representation or advertisement that these independent contractors are employees or agents of EMH.

❖ **Communication**

- I authorize EMH or its independent contractors to communicate with me in writing to any address that I have provided, to communicate with me orally or by text message to any telephone number I have provided (which could result in charges to me), and to communicate with me electronically at any email address I have provided.

❖ **Living Will, Advanced Directive, and Medical Orders for Scope of Treatment Information**

A. Living Will?

☐**No**	Patient/Family interested in information?	☐**Yes**	☐**No**
	Patient/Family given information?	☐**Yes**	☐**No**
☐**Yes**	Placed on chart	☐**Yes**	☐**No**
	Copy on file	☐**Yes**	☐**No**
	Patient/Family to bring in	☐**Yes**	☐**No**

B. Healthcare Power of Attorney (POA) or Healthcare Surrogate?

☐**No**	Patient/Family interested in information?	☐**Yes**	☐**No**
	Patient/Family given information?	☐**Yes**	☐**No**
☐**Yes**	Placed on chart	☐**Yes**	☐**No**
	Copy on file	☐**Yes**	☐**No**
	Patient/Family to bring in	☐**Yes**	☐**No**

Name of Agent _____

Relationship_____

By signing, I certify that I have read and understand the consent and authorizations given above, that I accept the terms on this form, and that I am the patient or I am duly authorized by the patient to execute this document and accept its terms. *I understand I have the right to revoke the authorizations on this form at any time by notifying EMH, in writing, except to the extent that EMH has already taken action in reliance upon them. These authorizations will remain valid until I revoke them.*

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority.

  ☐ Legal Guardian or Conservator
  ☐ Healthcare Agent (Healthcare Power of Attorney)
  ☐ Other Legal Representative
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

  ☐ Parent
  ☐ Legal Guardian
  ☐ Other Legal Representative

Signature _____ Date _____

Printed Name of Person Signing (If not patient): _____

Witness _____ Date _____

Witness _____ Date _____