Sanford Vaccine Patient Registration Form

*All Fields Required

Date: _____

PATIENT INFORMATION:			
Patient's Full Legal Name:	Preferred Name:	DOB:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

EMERGENCY CONTACT INFORMATION:			
Name:	Relationship to Patient:	Address:	Phone: Home or Cell (Circle One)

GUARANTOR INFORMATION (Who should receive the Sanford Statement):			
Name:	DOB:	Relationship to Patient:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

PRIMARY INSURANCE COVERAGE:			
Insurance Name, Address and Phone Number:	Group Number:	ID Number:	
Subscriber Name:	DOB:	Relationship to Guarantor:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

SECONDARY INSURANCE COVERAGE (IF APPLICABLE):			
Insurance Name, Address and Phone Number:	Group Number:	ID Number:	
Subscriber Name:	Subscriber DOB:	Relationship to Guarantor:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

Statement of Financial Responsibility and Release of Information

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Sanford. If I have questions about my financial responsibility for Sanford's charges, or would like to see a copy of Sanford's Collection Policy; I may contact Sanford's Patient Financial Services.

Further, if I am provided health care services by a health care provider other than Sanford, while a patient within a Sanford facility or entity, I am financially responsible for all charges related to services provided by those health care providers. Sanford's billing statements will not include charges by health care providers who are independent of Sanford.

As a patient, I have given or will give Sanford Health or one of its affiliates my home phone number, mobile phone number, email address, and/or other contact information. By signing below, I agree to be contacted by Sanford Health, its affiliates, and/or a company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails, and/or similar methods. The purpose for these messages may include appointment reminders or other health care messages, patient feedback, surveys, marketing or promotional messages, upcoming events, unpaid balance messages, and/or other business messages.

ASSIGNMENT OF PAYER BENEFITS

I agree Sanford and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. I agree this necessary health information will include treatment for substance abuse disorders if I receive those type of services. All Payers may make payments directly to Sanford and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to Sanford and my attending health care provider. I agree that unless Sanford or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Sanford and my attending health care provider for any services furnished me by Sanford and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLEDGMENT

I have read the information above, and have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the above label or on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

Relationship to Patient:

_____ I am the Patient _____ I am the Parent/Guardian _____ I am the POA

_____ _____ _____ a.m./p.m.

Signature of Patient or Authorized Person Date Time

SANFORD HEALTH

Acknowledgment of Notice of Privacy Practices

Patient's Name

_____

Patient's Medical Record Number

_____

Patient's Date of Birth (mm/dd/yyyy)

_____/_____/_____

(Or Affix Label)

I have received a copy of the Sanford Health Notice of Privacy Practices or it has been made available to me on Sanford Health's website at www.sanfordhealth.org/privacy-of-health.

The Notice describes how Sanford Health may use and disclose my health information.

Relationship to Patient:

_____ I am the Patient

_____ I am the Parent/Guardian

_____ I am the POA

Patient's Signature

_____Date _____ Time _____ am/pm

Or/By _____Date _____ Time _____ am/pm

Written Acknowledgment Not Obtained

Staff member made a good faith effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices but was unable to for the following reason:

- ☐ Notice Provided - Patient/Personal Representative refused to sign
- ☐ Notice Provided - Patient/Legal Representative unable to sign
- ☐ Notice Provided - Awaiting Signature

_____Date _____ Time _____ am/pm

Employee Signature

SANFORD HEALTH

Influenza Vaccine Downtime Documentation

If available, place patient identification sticker here

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____ Patient's Age: _____

If an Influenza Injection Vaccine Minor Consent Form or Influenza Intranasal Vaccine Minor Consent Form was completed, please use to answer the below questions.

If not previously asked, please answer the below questions:
Is the patient sick today? ☐ Yes ☐ No

Does the patient have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No

Has the patient ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No

Has the patient ever had Guillain-Barre syndrome? ☐ Yes ☐ No

Was verbal permission for vaccination obtained? ☐ Yes ☐ No

If giving intranasal formulation (FluMist) the additional questions below are required:
Does the patient have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia, or another blood disorder? ☐ Yes ☐ No

Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problems? ☐ Yes ☐ No

In the past 3 months, has the patient taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or had radiation treatments? ☐ Yes ☐ No

Is the patient receiving influenza antiviral medications? ☐ Yes ☐ No

Is the patient to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin therapy or aspirin-containing therapy? ☐ Yes ☐ No

Is the patient pregnant or is there a chance she could become pregnant during the next month? ☐ Yes ☐ No

Does the patient live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit) ? ☐ Yes ☐ No

Has the patient received vaccinations in the past 4 weeks? ☐ Yes ☐ No

Medication

SANFORD HEALTH

Influenza Vaccine Downtime Documentation

If available, place patient identification sticker here

Circle all that apply

Type of Vaccine	Dose	Manufacturer	Lot # and Expiration Date (or place sticker)	Site of Vaccine
Quadrivalent (IIV) Quadrivalent (18+ years) (RIV/Flublok) High Dose (65+ years) (IIV) Intranasal (FluMist) (2-49 years)	0.2 mL 0.5 mL 0.7 mL	AstraZeneca/Medimmune Sanofi Pasteur GlaxoSmithKline		Left Right Deltoid Vastus Lateralis NAS

_____ _____ _____

Signature and credentials of person administering | Date | Time

_____

Printed name of person administering

Influenza Injection Vaccine Minor Consent Form

If available,
place patient identification sticker here

Child Name: _____ Date of Birth: _____

Does your child have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No

Has your child ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No

Has your child ever had Guillain-Barre syndrome? ☐ Yes ☐ No

If you answered yes to any of the above questions your child will not be able to receive the flu shot at this event. If you would like your child to receive an influenza vaccine, please contact your child's health care provider.

To learn more about the flu shot please visit: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

Parent/Guardian understands and consents to vaccine.

_____ _____ _____
Signature of person to receive vaccine Date Time

_____ _____ _____
Signature of Parent/Legal Guardian Date Time

_____
Print name of Parent/Legal Guardian

_____
Relationship to patient

_____
Phone number of Parent/Legal Guardian

Influenza Intranasal Vaccine Minor Consent Form (2 through 17 years)

If available,
place patient identification sticker here

Child Name: _____ Date of Birth: _____

Does your child have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No

Has your child ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No

Has your child ever had Guillain-Barre syndrome? ☐ Yes ☐ No

Does your child have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia, or another blood disorder? ☐ Yes ☐ No

Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problems? ☐ Yes ☐ No

In the past 3 months, has your child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or had radiation treatments? ☐ Yes ☐ No

Is your child receiving influenza antiviral medications? ☐ Yes ☐ No

Is your child age 2 through 4 years, and in the past 12 months had a healthcare provider tell you the child had wheezing or asthma? ☐ Yes ☐ No

Is your child or teen age 6 months through 17 years and receiving aspirin therapy or salicylate-containing medicine? ☐ Yes ☐ No

Is your child pregnant or is there a chance she could become pregnant during the next month? ☐ Yes ☐ No

Does your child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? ☐ Yes ☐ No

Has your child received vaccinations in the past 4 weeks? ☐ Yes ☐ No

If you answered yes to any of the above questions your child will not be able to receive the FluMist at this event. If you would like your child to receive an influenza vaccine, please contact your child's health care provider.

To learn more about the FluMist please visit: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf

Influenza Intranasal Vaccine Minor Consent Form (2 through 17 years)

If available,
place patient identification sticker here

Parent/Guardian understands and consents to vaccine.

Signature of person to receive vaccine	Date	Time
Signature of Parent/Legal Guardian	Date	Time

Print name of Parent/Legal Guardian

Relationship to patient

Phone number of Parent/Legal Guardian