COMMUNITY HEALTHCARE CENTER
SIGNATURE ON FILE

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Community Healthcare Center, for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that; payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item #9 on the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare sign cases, the provider or supplies agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible co-insurance and non-covered services Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____

Printed Name: _____ Date: _____

Medicare # _____ Medicaid # _____

Insurance Company: _____

Group # _____ Member ID # _____

NOTICE OF CONCERNING: Complaints about physicians, as well as other licensees an registrants of the Texas State Board of Medical Examiners, including physician assistants an acupuncturists, may be reports for investigation at the following address : Texas State Board of Medical Examiners, Attention Investigations, 1812 Center Creek Drive, Suite 300. P.O. Box 149134, Austin, Texas 78714-9134.
Assistance in filing a complaint is available by calling the following: 1-800-201-9353

COMMUNITY HEALTHCARE CENTER
SIGNATURE ON FILE

Solicito que Community Healthcare Center reciba el pago de los beneficios autorizados de Medicare, Medicaid u otros seguros a mi nombre por cualquier servicio que me brinde el proveedor o suministrador indicado en la lista. Autorizo a cualquier poseedor de información médica sobre mi persona a divulgar a la Administración para el Financiamiento de Servicios de Salud y a sus agentes cualquier información necesaria para determinar dichos beneficios o los beneficios pagaderos por servicios relacionados.

Entiendo que por medio de mi firma solicitó realizar el pago y autorizo la divulgación de la información médica necesaria para pagar la reclamación. Si en el punto 9 del formulario HCFA-1500 se ha indicado "Otro seguro médico", o bien en otro lugar de otros formularios de reclamaciones aprobados o presentados electrónicamente, mi firma autoriza la divulgación de la información a la aseguradora o agencia indicada. En los casos asignados de Medicare el proveedor o suministrador acuerda aceptar el cargo fijado por la compañía de seguros de Medicare como cargo total y el paciente es responsable únicamente de los deducibles del conseguro y de los servicios no cubiertos. El coseguro y el deducible se basan en el cargo fijado por la compañía de seguros de Medicare.

Firma: _____

Nombre:_____ Fecha: _____

Medicare # _____ Medicaid # _____

Compañía de Seguros: _____

Grupo # _____ Miembro ID # _____

AVISO RESPECTO A POSIBLES QUEJAS:
Las quejas de médicos, así como otros licenciatarios y registrantes de la Junta Estatal de Examinadores Médicos de Tejas incluidos los asistentes médicos y acupunturistas, puedan ser reportadas para su investigación a la siguiente dirección: Texas State Board of Medical Examiners, Attention Investigations, 1812 Center Creek Drive, Suite 300. P.O. Box 149134, Austin, Texas 78714-9134.
Si necesita asistencia para presentar una queja llame al: 1-800-201-9353

Community Healthcare Center
Reaching Out To Everyone

PFIZER BIONTECH COVID-19 VACCINE CONSENT FORM

DEMOGRAPHIC INFORMATION

Last Name	**First Name**
Date of Birth	
Emergency Contact Name/Relation	**Phone**

VACCINE ELIGIBILITY SCREENING

The following questions will help us in determining if receiving the vaccine is a right for you.
Please mark **YES, NO, or N/A** for each question.

	YES	NO	N/A
1. Are you experiencing any **NEW/ATYPICAL** onset of the following: fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle/body aches, headache, loss of taste/smell, sore throat, nausea, vomiting, diarrhea?			
2. Have you received any vaccinations in the past two (2) weeks? If yes, please list _____			
3. Have you received any other COVID-19 vaccine***, at any time***? If yes, please list date/where _____			
4. Do you have a known allergy to **polyethylene glycol (PEG), polysorbate,** or any of the listed components of the Pfizer COVID-19 Vaccine? **The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.**			
5. Have you ever been diagnosed with COVID-19 infection? If yes, please list date _____			
6. **If you answered yes to Q.5**, did you receive any antiviral or antibody therapies?			
7. Are you currently, or within the last two weeks, been monitored for COVID-19 or are a close/household contact to an individual with a COVID-19 diagnosis?			
8. Do you have a severe/anaphylactic allergy or required the carry/use of an Epi-Pen? If yes, please list _____			
9. Have you ever experienced a severe reaction to a vaccination? If yes, please explain _____			
10. Within 4 hours of your **1st COVID vaccine**, did you experience any non-severe allergic reactions **Ex. itching, swelling, or hives to body; difficulty breathing or wheezing**			
11. Do you have a bleeding disorder or take a blood thinner? Or have you received blood, blood products, or immune (gamma) globulin/antiviral medication within last 6 months? **(Ex. Coumadin, Eliquis, Lovenox, Pradaxa, Xarelto, Brilinta, Plavix)**			
12. Are you immunocompromised, have history of a weakened immune system, or an autoimmune disorder? **(This may include radiation, medications, or biologicals given to suppress your immune system)**			
13. Have you ever been diagnosed seizures, epilepsy, Bell's palsy, brain/neurological disorders or experienced Guillain-Barre Syndrome?			
14. Are you pregnant, plan on becoming pregnant, or are you currently breastfeeding?			

Community Healthcare Center
Reaching Out To Everyone

If you answered "YES" to any of the questions 1 to 4 you should not have the Pfizer vaccine today:

- If you are sick, we recommend you delay vaccination until your symptoms have resolved. If you're diagnosed with COVID-19 you should delay the vaccination for 90 days after diagnosis.
- If you have received other vaccination(s) recently for something other than COVID-19, it is **recommended** that you wait two weeks following that vaccine prior to receiving the Pfizer vaccine.
- If you have received a different COVID-19 vaccine you should not receive the Pfizer vaccine as there is no data on safety or efficacy of combining vaccines from different manufacturers.
- If you have been diagnosed with COVID-19 at any time within the past 90 days, we **recommend** waiting 90 days from your diagnosis before getting the Pfizer vaccine.
- **If you have a history of anaphylaxis to any of the ingredients in the Pfizer vaccine, you should not receive the Pfizer vaccine at any time based on current guidance.**

If you answered "YES" to questions 5 to 11, notify the staff post before receiving the Pfizer vaccine.

- If you have a history of anaphylaxis to something other than the Pfizer vaccine ingredients, we may wish to delay vaccination, refer you to another vaccine provider, or increase your monitoring time after vaccination to make sure that there is no evidence of anaphylactic reaction. If you have a history of a bleeding disorder or take a blood thinner we will monitor for bleeding at the injection site.

If you answered "YES" to questions 12 to 14 you can choose to have the Pfizer vaccine today with the understanding that there is not yet good data on safety and efficacy for the Pfizer vaccine in these groups.

CONSENT FOR VACCINATION

The Pfizer BioNTech COVID-19 Vaccine made by Pfizer has been authorized by the Federal Drug Administration (FDA) under the Emergency Use Authorization (EUA). The FDA may issue an EUA based on a declaration by the Secretary of the Department of Health and Human Services (HHS) that circumstances justify emergency use of the drugs and biological products during the COVID-19 pandemic, if certain criteria are met. Those criteria include that there are no adequate FDA approved alternatives available. There is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine. The FDA decision to issue a EUA is based on the totality of the scientific evidence available showing that the Pfizer vaccine may be effective to prevent COVID-19 and that the known and potential benefits of the Pfizer vaccine outweighs the known and potential risks.

North Central Texas Community Healthcare Center Is authorized to offer the Pfizer vaccine based on guidance from the Centers for Disease Control and the Texas Department of State Health Services. The Pfizer vaccine will be provided at no charge. The Pfizer vaccine requires two doses given 21 days apart to be effective.

Pfizer vaccine side effects that have been reported in clinical trials include, but are not limited to: injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, swollen lymph nodes. These symptoms are not severe in the majority of cases, and usually resolved within 24 hours. Adverse side effects should be reported to CHC at 940.766.6306. Certain severe allergic reactions have been reported outside of clinical trials; if you develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain, fast heartbeat, dizziness, weakness swelling of the face, throat, or tongue, or a rash all over your body) call 911 or go to your nearest Hospital Emergency Department.

Community Healthcare Center
Reaching Out To Everyone

- I have read and/or had read and explained to me the Emergency Use Authorization (EUA) of the Pfizer COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in individuals 16 Years of Age and Older Fact Sheet for Recipients and Caregivers.

- I understand that the FDA has authorized use of the Pfizer Vaccine under the Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 Vaccine.

- I understand the known risks and the potential benefits of receiving the Pfizer Vaccine and I understand there may be risks to the Pfizer vaccine that are not known at this time.

- I have been given the opportunity to ask questions. And all questions I have regarding the vaccine, vaccination process, side effects, and follow up have been answered to full understanding and satisfaction.

- I understand and agree that Community Healthcare Center is required to submit COVID-19 vaccine administration data to the Texas Department of State Health Service's Texas Immunization Registry (ImmTrac2) System and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

- I understand to receive full effect, that the Pfizer Vaccine will be given in two (2) separate doses, 21 days apart, and I will make every conscious effort to receive both doses.

- I understand it is required that I remain on site for at least **15 minutes** after receiving the Pfizer vaccine and that depending on the recommendations of medical professionals I may be asked to remain on site longer for monitoring.

PLEASE INITIAL:

_____ **I GIVE CONSENT** for *NORTH CENTRAL TEXAS COMMUNITY HEALTHCARE CENTER* and its staff to vaccinate me today.

Signature of Recipient: _____ **Date: _____ / _____ / _____**

Signature of Reviewer: _____ **Date: _____ / _____ / _____**

FOR ADMIN USE ONLY

Date Vaccine Administered	Route	Site	Lot #	Exp. Date	Signature & Title of Administrator
#1	IM	Lt. / Rt. Deltoid			
#2	IM	Lt. / Rt. Deltoid			