**COVID-19 Immunization Screening and Consent Form**

**Primary Series for New Patient 6mo - 17yr**

**6个月 - 17周岁新病人登记表 & 新冠疫苗接种筛查问卷及疫苗接种同意书**

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| **Patient Information** |
| Last Name姓 | First Name名 | Middle Name | Gender:性别:  | Date of Birth 出生日期: MM月 **/** DD日 **/** YY年 |
| Mailing Address住宅地址:  |
| Home Phone # 住宅电话: | Cell Phone # 手机号码: |
| Parent/Legal Guardian 父母/监护人 Last姓 First 名 |
| Email 电子邮件: | Preferred Language 语言偏好: |
| Parent/Legal Guardian父母/监护人 Last姓 First 名 |
| Email 电子邮件: | Preferred Language 语言偏好: |
| Emergency Contact 紧急联系人名字: |
| Emergency Contact Phone # 电话号码: | Relationship to patient 与病人关系: |
| Mother/Father/Guardian(circle one) 's DOB 母亲/父亲/监护人(选一)的出生日期: MM月 **/** DD日 **/** YY年 |
| *I hereby request and consent to Rendr disclosing my protected health information to my emergency contact.**我特此要求并同意仁德医生集团把我的个人医疗信息公开给我的紧急联系人* |
| **Insurance Information** |
| Insurance Company & ID Number:保险公司名称 &保险号码: | Relationship to Insured 病人与受保人关系: □ Self 自己 □ Child子女 □ Other其他 |
| Insured (Card Holder) Name 受保人姓名: | Insured’s DOB受保人出生日期: MM月 **/** DD日 **/** YY年 |
| Secondary Insurance & ID Number:第二保险 &保险号码: | Relationship to Insured 病人与受保人关系: □ Self 自己 □ Child子女 □ Other其他 |
| Insured (Card Holder) Name受保人姓名: | Insured’s DOB受保人出生日期: MM月 **/** DD日 **/** YY年 |
| **Social History** |
| Preferred Pharmacy 药房: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Phone # 药房电话号码:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Agreement** |
| **I hereby authorize direct payment of medical benefits to Rendr for services rendered by the Practice.****I understand that I am financially responsible for any balance if my insurance is terminated or the service is not covered.****我同意由我受保的保险公司直接支付仁德医生集团所提供的医疗服务费用。****我明白如果我的医疗保险无效或不支付部分医疗服务，我需负责支付诊金和医疗费用。** |
| **Printed Name** of Parent/Guardian / Authorized Representative父母/监护人/代表正楷姓名: | Relationship 与病人关系: |
| **Signature** of Parent/Guardian /Authorized Representative: 父母/监护人/代表签名 | Date 日期: |

# Last, First Name: DOB:

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| **COVID-19 Vaccine Screening Questionnaire****新冠疫苗接种筛查问卷** |
| 1. | Are you feeling sick today?您今天感觉不适吗？ | [ ]  Yes 是 | [ ]  No 否 |
| 2. | In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?在过去的10天中，您是否曾因新冠感染或暴露而接受过新冠检测，或被医务人员或卫生部门告知要隔离或在居家隔离？ | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 3. | Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_在过去90天（3个月），您是否曾接受过抗体疗法或新冠的恢复期血浆治疗？如果是，您什么时候收到最后一剂？日期：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 4. | Have you ever had an immediate allergic reaction to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?您是否曾对任何疫苗，注射剂或新冠疫苗的任何成分产生严重或危及生命的过敏反应 (例如荨麻疹、面部肿胀、呼吸困难、过敏性休克)，或有任何严重的过敏症 / 过敏史? | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 5. | Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?您是否患有出血性疾病或正在服用抗凝血药？ | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 6. | Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?您是否有心肌炎（心肌发炎）或心包炎（心脏周围的纤维囊发炎）的病史？ | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 7. | Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA? (E.g., AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm)您之前是否接种过 WHO 授权但未获得 FDA 授权的新冠疫苗？（如：AstraZenec – VAXZEVRIA 阿斯利康、Sinovac – CORONAVAC 中国科舆、Serum Institute of India 印度血清研究所 - COVISHIELD、Sinopharm 中国国药） | [ ]  Yes是 | [ ]  No否 | [ ]  Unknown未知 |
| 8. | Have you received a previous dose of the COVID-19 vaccine?  [ ]  **Yes** [ ]  **No If yes, which vaccine?**您是否曾经接种过新冠疫苗？ **☐ 是 ☐ 否 如果是，请问哪种疫苗？** | [ ]  Moderna莫德纳 | [ ]  Pfizer辉瑞 |

[ ]

[ ] **Emergency Use Authorization**

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA’s decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 6 months through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

**紧急用户许可证** FDA已根据紧急用户许可证（EUA）提供了新冠疫苗。EUA是需要在紧急情况下紧急使用药物和生物产品，例如目前新冠大流行。 该疫苗尚未完成与FDA批准或批准的产品相同类型的审查。 但是，FDA决定根据EUA提供疫苗的决定是基于公共卫生突发事件的存在以及可获得的全部科学证据，这表明疫苗的已知和潜在益处超过了已知和潜在风险。请注意：FDA批准新冠瑞疫苗为16岁及以上人群的两剂系列疫苗。 根据紧急用户许可证（EUA）辉瑞疫苗可继续提供给特定人群，包括6个月至15岁的人群以及符合以下同意书中规定的特定人群。

**Consent**

I (the parent / guardian) have read, or had explained to me, the information sheet about the COVID-19 vaccination. I (the parent / guardian) understand that if my vaccine requires two doses, I (the parent / guardian) will need to be administered (given) two doses to be considered fully vaccinated.

**同意书** 我(父母 / 监护人)已阅读或已向我 (父母 / 监护人)解释过有关新冠疫苗接种的信息。 我(父母 / 监护人)明白， 如果接受的疫苗是两剂系列疫苗，接种者需要接种两剂才能被视为完全接种疫苗。

I (the parent / guardian) have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I (the parent / guardian)  understand the benefits and risks of the vaccination as described.

我(父母 / 监护人)有机会提出问题，这些问题的回答令我(父母 / 监护人)满意（并确保我有权代表的上述人员提供代理同意也有机会提问）。 我(父母 / 监护人)了解所描述的疫苗接种的益处和风险。

I (the parent / guardian) request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I (the parent / guardian)  understand there will be no cost to me for this vaccine. I (the parent / guardian) understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I (the parent / guardian) authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

我(父母 / 监护人)要求接受新冠疫苗接种（或上面已获我授权的人提出请求并提供代理同意）。 我(父母 / 监护人)知道这种疫苗不会给接种者带来任何费用。 我(父母 / 监护人)了解将分配给疫苗的任何款项或利益， 并转移给提供疫苗接种者， 包括健康保险计划，Medicare， Medicaid或其他对我的医疗费用负有经济责任的第三方。 我 (父母 / 监护人)授权发布所有必要的信息 （包括但不限于医疗记录， 医疗账单细则） 以核实付款情况， 以及其他公共卫生防疫目的所需的信息， 包括向当地卫生部门疫苗注册机构告。

I (the parent / guardian) acknowledge and consent that information regarding my identity and all my immunizations will be released to the New York Citywide Immunization Registry (CIR).

我(父母 / 监护人)确认并同意，有关接种者的身份和所有疫苗接种的信息将被发布到纽约市范围内的免疫注册中心(CIR)。

Parent/Guardian (Signature) Date / Time Print Name Relationship to patient

父母/监护人(签名) 日期/时间 正楷签名 接受疫苗接种者的关系

#  Last, First Name: DOB:

|  |
| --- |
| **Area Below to be Completed by Vaccinator****此处由提供疫苗接种者填写** |
| **Which vaccine is the patient receiving today?****患者今天正在接受哪种疫苗** |
| Vaccine Name疫苗名称 |  | EUA Fact Sheet DateEUA情况说明书日期 | Lot Number批号 |
|  Pfizer/ BioNTech 辉瑞 | [ ]  1st Dose第一剂 | [ ]  2nd Dose第二剂 | [ ]  3rd Dose第三剂**(6mo - 4yr Only)** |  |  |
|  Moderna 莫德纳 | [ ]  1st Dose第一剂 | [ ]  2nd Dose第二剂 |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Administration Site:注射部位 | [ ]  Left Deltoid 左手臂 | [ ]  Right Deltoid 右手臂  | [ ]  Left Thigh 左大腿 | [ ]  Right Thigh 右大腿 |
|  |  |  |  |  |
| Dosage:剂量 | [ ]  0.2 mL 0.2毫升 | [ ]  0.3 mL 0.3毫升 |  |  |

[ ]  I have reviewed side effects with patient (and parent, guardian, or surrogate, as applicable)

我已经与接受疫苗接种者（和父母，监护人或代理人，如果适用）一起审查了不良反应

[ ]  I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

我确认接受疫苗接种者（及其代理人，如果适用）有机会询问有关疫苗接种的问题以及他们提出的所有问题（和/或他们的替代问题）均已尽我所能正确回答

Vaccinator Signature:

提供疫苗接种者签名

**CONSENT FORM 同意书**

**Notice of Privacy Practices:**

I acknowledge and agree that I have had the right to review a copy of Chinatown True Care Medical, PLLC’s (“Rendr”) Notice of Privacy Practices prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my protected health information (“PHI”). I hereby consent to Rendr using and disclosing my PHI to carry out treatment, payment, and healthcare operations (“TPO”), including sharing my PHI with my primary care physician, if applicable, outside providers who are involved in my care, organized health care arrangements (“OHCA”) with which Rendr participates as well as other providers within the OHCA, networks such as IPAs and accountable care organizations that coordinate care for providers who may treat me, affiliate entities that coordinate or provide continuity of my care, as well as insurers to obtain payment. I also hereby consent to the Practice disclosing my immunization history to health oversight agencies/registries for syndromic surveillance. You have the right to request that Rendr restrict how your PHI is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, Rendr shall honor that agreement. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures Rendr has already made in reliance on your prior Consent. The terms of Rendr’s Notice may change. If Rendr changes the Notice, you may obtain a revised copy by contacting our office.

**隐私权惯例通知:**

本人确认并同意，在签署本同意书之前，本人有权查阅 Chinatown True Care Medical, PLLC’s (“Rendr”) 的《隐私权惯例通知》；该通知向本人提供了关于潜在使用和透露本人受保护健康信息 (“PHI”) 的更完整说明。 本人在此同意 Rendr使用和透露本人的 PHI 来进行治疗、付款和医疗保健业务 (“TPO”) ，包括与本人的主治医生 (若适用) 、参与本人护理的外部提供者、Rendr参与的有组织医疗保健安排 (“OHCA”) 以及OHCA内的其他提供者、各种网络 (如IPA和协调可能为本人提供护理的提供者的负责制医疗组织) 以及保险公司共享本人的PHI，以获得付款。 此外，本人在此同意诊所将本人的免疫接种史透露给卫生监督机构/登记处，以进行综合症监测。 您有权要求Rendr限制出于治疗、付款或健康护理运作的目的使用或透露您的受保护健康信息。 我们无需同意此限制，但若我们同意，Rendr将遵守该协议。 您有权透过签名的书信来撤销本同意书。 然而，该撤销不应影响Rendr已依据您的事先同意作出的任何透露。 Rendr的通知条款可能会发生改变。 若Rendr修改通知，您可以联系我们的办公室获取一份修订版副本。

**The patient understands that 病人需了解:**

* Protected health information may be disclosed or used for treatment, payment, or health care operations;

受保护的健康信息可能会被透露，或用于治疗、付款或医疗保健业务；

* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;

医疗者拥有此“隐私通知”，而病人有权审查此通知；

* The Practice reserves the right to change the Notice of Privacy Practices;

医疗者保留修改此“隐私通知”的权利；

* The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions;

病人有权提出要求或限制我们如何使用其信息，但医疗者不必同意此要求或限制；

* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

病人可于任何时间以书面形式撤销此项同意及未来所有的信息披露，然后将停止。

**Consent to Contact 同意联络:**

I hereby consent to the Practice, or its designee, calling my home, cell phone, business phone or other designated location, through the use of an automated dialing system, prerecorded voice message, or other method as deemed appropriate by the Practice, and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO such as appointment reminders, insurance items, information pertaining to my clinical care, including laboratory results, and other matters incident to my treatment.

本人在此同意诊所或其指定人员透过使用自动拨号系统、预先录制的语音短讯或诊所认为合适的其他方法给本人的家庭、手机、办公电话或其他指定地点打电话，并在本人的语音信箱或当面留言，说明可协助诊所执行 TPO 的任何项目，如预约提醒、保险事项、与本人的临床护理有关的信息 (包括化验结果)、以及其他与本人治疗相关的事项。

In accordance with HIPAA and the Telephone Consumer Protection Act, I hereby consent to the Practice mailing me materials to my home or other designated location, text messaging (through an automated texting system or otherwise) or e-mailing me regarding any items pertaining to my clinical care, or payment for services, including PHI and other matters incident or related to treatment or healthcare, such as appointment reminders and patient statements. I acknowledge that the Practice cannot and does not guarantee the privacy, security, or confidentiality of an e-mail message or text message sent or received.

本人在此同意诊所将相关数据邮寄到本人的住所或其他指定地点、(透过自动短讯系统或其他方式) 向本人传送短讯、或向本人传送电子邮件，说明与本人临床护理或服务付款有关的任何项目，包括受保护健康信息和其他治疗相关事项，如预约提醒和患者声明。 本人确认，诊所不能、也不会保证所传送或接收的电子邮件或短讯的隐私性、安全性或保密性。

I hereby consent to the Practice communicating with the following individual(s) regarding my PHI:

本人在此同意，诊所会与以下个人针对本人的受保护健康信息进行沟通：

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(姓名) (关系) (电话)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(姓名) (关系) (电话)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(姓名) (关系) (电话)

This consent shall specifically include the release of test results and the right to receive prescriptions. I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

此同意应具体包括检测结果的公布和接受处方的权利。本人明白，本人有权要求诊所限制其使用或透露本人的受保护健康信息以执行 TPO 的方式。 然而，诊所无需同意本人所要求的限制，但若同意，则受此协议约束。

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for use and disclosure of PHI. I understand that I may revoke my consent in writing, except to the extent that the Practice has already make disclosures in reliance upon my prior consent.

本人在此表格上签名，即表示本人同意诊所按照《隐私权政策》和此《使用和透露受保护健康信息患者同意书》的规定使用和透露本人的受保护健康信息。 本人理解，本人可以透过书面形式撤销本人的同意，但该类撤销不影响诊所已依据本人的事先同意进行的透露。

**This Consent was signed by:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name 名字正楷 Signature 签名

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_

 Relationship to Patient与病人关系 Date 今天日期