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

**For New Adult Patient**

**成人新病人登記表 & 新冠疫苗接種篩查問卷及疫苗接種同意書**

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| **Patient Information** |
| Last Name姓  | First Name 名   | Middle Name | Chinese Name中文姓名: |
| Date of Birth 出生日期: MM月 **/** DD日 **/** YY年  | Gender 性別:  | Race 種族: |
| Marriage Status 婚姻狀態: □Single單身 □Married已婚 □Other其他 | Preferred Language:語言偏好: |
| Mailing Address 住宅地址: |
| Home Phone # 住宅電話:  | Cell Phone # 手機號碼:  |
| Email 電子郵件:  |
| Emergency Contact 緊急連絡人名字:  |
| Emergency Contact Phone # 電話號碼: | Relationship to patient 與病人關係: |
| *I hereby request and consent to Rendr disclosing my protected health information to my emergency contact.**我特此要求並同意仁德醫生集團把我的個人醫療資訊公開給我的緊急連絡人* |
| **Insurance Information** |
| **Insurance Carrier 保險公司名字:**  | Insurance ID # 保險卡號碼: |
| Medicare # 紅藍卡號碼: | Medicaid # 白卡號碼: |
| Relationship to Insured 病人與受保人關係: □Self 自己 □Spouse 配偶 □Child子女 □Other 其他 |
| Insured Name 受保人名字: | Sex 性別: | DOB 出生日期: |
| **Secondary Insurance 第二保險:**  | Insurance ID # 保險卡號碼: |
| Relationship to Insured 病人與受保人關係: □Self 自己 □Spouse 配偶 □Child子女 □Other 其他 |
| Insured Name 受保人名字: | Sex 性別: | DOB 出生日期: |
| **Social History** |
| Preferred Pharmacy 藥房: Pharmacy Phone # 藥房電話號碼: |  |
| Pharmacy Address 藥房地址:  |
| Previous/Referring PCP 之前/轉診的家庭醫生: Office Phone # 診所電話號碼: |
| **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 Patient/Guardian/Authorized Representative本人/監護人/代表正楷姓名: | Relationship 與病人關係: |
| **Signature** of Patient/Guardian/Authorized Representative: 本人/監護人/代表簽名: | Date 日期: |

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| **COVID-19 Vaccine Screening Questionnaire****新冠疫苗接種篩查問卷** |
| 1. | Are you feeling sick today?您今天感覺不適嗎？ | [ ]  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?在過去的10天中，您是否曾因新冠感染或暴露而接受過新冠檢測，或被醫務人員或衛生部門告知要隔離或在居家隔離？ | [ ]  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_在過去90天（3個月），您是否曾接受過抗體療法或新冠的恢復期血漿治療？如果是，您什麼時候收到最後一劑？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?您是否曾對任何疫苗，注射劑或新冠疫苗的任何成分產生嚴重或危及生命的過敏反應 (例如蕁麻疹、面部腫脹、呼吸困難、過敏性休克)，或有任何嚴重的過敏症 / 過敏史? | [ ]  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藥？ | [ ]  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（心肌發炎）或心包炎（心臟周圍的纖維囊發炎）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)您之前是否接種過 WHO 授權但未獲得 FDA 授權的新冠疫苗？（如：AstraZenec – VAXZEVRIA 阿斯利康、Sinovac – CORONAVAC 中國科輿、Serum Institute of India 印度血清研究所 - COVISHIELD、Sinopharm 中國國藥） | [ ]  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?**您是否曾經接種過新冠疫苗？ **☐ 是 ☐ 否 如果是，接種了哪種疫苗？** | [ ]  Moderna莫德納 | [ ]  Pfizer輝瑞 | ☐ Janssen強生 |

[ ]

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| **Please answer Q9 OR Q10a & 10b if you come for additional or booster dose****如果您是來接種追加劑或加強劑, 請回答問題9或10a和10b** |
| 9. | **For Additional Dose (immunocompromised patient) ONLY (Monovalent)**Have you completed 1-dose series of Jassen vaccine OR 2-dose series of Pfizer/Moderna vaccine, the last dose being at least 4 weeks?**如果您是來因罹患免疫功能缺陷接種追加劑：**距完全接種強生的單劑新冠疫苗, 輝瑞或莫德納新冠疫苗系列的最後一劑疫苗至少間隔 4 周? | [ ]  Yes 是 | [ ]  No 否 |
| 10a. | **For Booster Dose ONLY (Bivalent)**Have you completed a primary vaccine series, that last dose (primary or monovalent booster) being at least 2 months ago?**如果您是來接種二價加強劑：**距最後一次接種新冠疫苗（單價疫苗）至少間隔 2 個月? | [ ]  Yes 是 | [ ]  No 否 |
| 10b. | Have you received JYNNEOS vaccine recently?If yes, was the most recent dose at least 4 weeks ago? [ ]  **Yes** [ ]  **No** 您最近有接種天花/猴痘疫苗嗎？  如果是，距最近一劑至少間隔 4 周嗎？**☐ 是 ☐ 否** | [ ]  Yes 是 | [ ]  No 否 |

**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.

**緊急使用授權** FDA已根據緊急使用授權（EUA）提供了新冠疫苗。EUA是需要在緊急情況下緊急使用藥物和生物產品，例如目前新冠大流行。 該疫苗尚未完成與FDA批准或批准的產品相同類型的審查。 但是，FDA決定根據EUA提供疫苗的決定是基於公共衛生突發事件的存在以及可獲得的全部科學證據，這表明疫苗的已知和潛在益處超過了已知和潛在風險。請注意：FDA批准輝瑞新冠疫苗為16歲及以上人群的兩劑系列疫苗。 根據緊急使用授權（EUA）輝瑞疫苗可繼續提供給特定人群，包括6個月至15歲的人群以及符合以下同意書中規定的特定人群。

**Consent**

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

**同意書** 我已閱讀或已向我解釋過有關新冠疫苗接種的資訊。 我明白， 如果接受的疫苗是兩劑系列疫苗，接種者需要接種兩劑才能被視為完全接種疫苗。

I 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 understand the benefits and risks of the vaccination as described.

我有機會提出問題，這些問題的回答令我滿意（並確保我有權代表的上述人員提供代理同意也有機會提問）。 我瞭解所描述的疫苗接種的益處和風險。

I 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 understand there will be no cost to me for this vaccine. I 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 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.

我要求接受新冠疫苗接種（或上面已獲我授權的人提出請求並提供代理同意）。 我知道這種疫苗不會給接種者帶來任何費用。 我瞭解將分配給疫苗的任何款項或利益， 並轉移給提供疫苗接種者， 包括健康保險計畫，Medicare， Medicaid或其他對我的醫療費用負有經濟責任的協力廠商。 我授權發佈所有必要的資訊 （包括但不限於醫療記錄， 醫療帳單細則） 以核實付款情況， 以及其他公共衛生防疫目的所需的資訊， 包括向當地衛生部門疫苗註冊機構告。

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

我確認並同意，有關接種者的身份和所有疫苗接種的資訊將被發佈到紐約市範圍內的免疫註冊中心(CIR)。

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

接受疫苗接種者/代理人/監護人簽名 日期/時間 正楷簽名 接受疫苗接種者的關係

#  Last, First Name: DOB:

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| --- |
| **Area Below to be Completed by Vaccinator****此處由提供疫苗接種者填寫** |
| **Which vaccine is the patient receiving today?****今天病人接種了哪種疫苗？** |
| Vaccine Name疫苗名稱 |  | Fact Sheet Date情況說明書日期 | Lot Number批號 |
| Pfizer/BioNTech輝瑞 | [ ]  1st Dose第一劑 | [ ]  2nd Dose第二劑 | [ ]  Add. Dose追加劑 | [ ]  Booster Dose二價加強劑 |  |  |
| Moderna莫德納 | [ ]  1st Dose第一劑 | [ ]  2nd Dose第二劑 | [ ]  Add. Dose追加劑 | [ ]  Booster Dose二價加強劑 |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Administration Site:注射部位 | [ ]  Left Deltoid 左手臂 | [ ]  Right Deltoid 右手臂  |  |  |
|  |  |  |  |  |
| Dosage:劑量： | [ ]  0.3 mL 0.3毫升 | [ ]  0.5 mL 0.5毫升 |  |  |

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

我已經與接受疫苗接種者（和父母，監護人或代理人，如果適用）一起審查了不良反應

[ ]  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.

我確認接受疫苗接種者（及其代理人，如果適用）有機會詢問有關疫苗接種的問題以及他們提出的所有

問題（和/或他們的替代問題）均已盡我所能正確回答

Vaccinator Signature:

提供疫苗接種者簽名

**CONSENT FORM 同意書**

**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.

**隱私權慣例通知:**

本人確認並同意，在簽署本同意書之前，本人有權查閱 Chinatown True Care Medical, PLLC’s (“Rendr”) 的《隱私權慣例通知》；該通知向本人提供了關於潛在使用和透露本人受保護健康資訊 (“PHI”) 的更完整說明。 本人在此同意 Rendr使用和透露本人的 PHI 來進行治療、付款和醫療保健業務 (“TPO”) ，包括與本人的主治醫生 (若適用) 、參與本人護理的外部提供者、Rendr參與的有組織醫療保健安排 (“OHCA”) 以及OHCA內的其他提供者、各種網路 (如IPA和協調可能為本人提供護理的提供者的負責制醫療組織) 以及保險公司共用本人的PHI，以獲得付款。 此外，本人在此同意診所將本人的免疫接種史透露給衛生監督機構/登記處，以進行綜合症監測。 您有權要求Rendr限制出於治療、付款或健康護理運作的目的使用或透露您的受保護健康資訊。 我們無需同意此限制，但若我們同意，Rendr將遵守該協議。 您有權透過簽名的書信來撤銷本同意書。 然而，該撤銷不應影響Rendr已依據您的事先同意作出的任何透露。 Rendr的通知條款可能會發生改變。 若Rendr修改通知，您可以聯繫我們的辦公室獲取一份修訂版副本。

**The patient understands that 病人需瞭解:**

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

受保護的健康資訊可能會被透露，或用於治療、付款或醫療保健業務；

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

醫療者擁有此“隱私通知”，而病人有權審查此通知；

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

醫療者保留修改此“隱私通知”的權利；

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

病人有權提出要求或限制我們如何使用其資訊，但醫療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.

病人可于任何時間以書面形式撤銷此項同意及未來所有的資訊披露，然後將停止。

**Consent to Contact 同意聯絡:**

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.

本人在此同意診所或其指定人員透過使用自動撥號系統、預先錄製的語音短訊或診所認為合適的其他方法給本人的家庭、手機、辦公電話或其他指定地點打電話，並在本人的語音信箱或當面留言，說明可協助診所執行 TPO 的任何專案，如預約提醒、保險事項、與本人的臨床護理有關的資訊 (包括化驗結果)、以及其他與本人治療相關的事項。

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.

本人在此同意診所將相關資料郵寄到本人的住所或其他指定地點、(透過自動短訊系統或其他方式) 向本人傳送短訊、或向本人傳送電子郵件，說明與本人臨床護理或服務付款有關的任何專案，包括受保護健康資訊和其他治療相關事項，如預約提醒和患者聲明。 本人確認，診所不能、也不會保證所傳送或接收的電子郵件或短訊的隱私性、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，診所會與以下個人針對本人的受保護健康資訊進行溝通：

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

(姓名) (關係) (電話)

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

(姓名) (關係) (電話)

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

(姓名) (關係) (電話)

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.

此同意應具體包括檢測結果的公佈和接受處方的權利。本人明白，本人有權要求診所限制其使用或透露本人的受保護健康資訊以執行 TPO 的方式。 然而，診所無需同意本人所要求的限制，但若同意，則受此協議約束。

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.

本人在此表格上簽名，即表示本人同意診所按照《隱私權政策》和此《使用和透露受保護健康資訊患者同意書》的規定使用和透露本人的受保護健康資訊。 本人理解，本人可以透過書面形式撤銷本人的同意，但該類撤銷不影響診所已依據本人的事先同意進行的透露。

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

 Printed Name 名字正楷 Signature 簽名

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

 Relationship to Patient 與病人關係 Date 今天日期