VIP COMMUNITY SERVICES

REGISTRATION FORM

PATIENT INFORMATION

Legal last name: | Legal First: | Middle: | Today's date: / /

Chosen first name (if different): | Date of Birth: / / | Social Security number: - -

Billing Address: | Apartment #: | Cell phone number: ( ) | Which is your primary contact number? ☐ Cell ☐ Home ☐ Work

City: | State: | Home phone number: ( )

E-Mail Address for Patient Portal:
Must be 18 years of age or older

Work phone number: ( )

Preferred Pronoun:

☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these question were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank You.

Preferred Spoken/Written Language:
☐ English ☐ Spanish
☐ French ☐ Other

Language interpretation services needed?
☐ No
☐ Yes, language: _____

Race: * Select all that apply*
☐ Black and/or African American ☐ White/Caucasian
☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ More than one race
☐ Decline to Answer

Veteran? ☐ Yes ☐ No

Migrant Worker?
☐ Yes ☐ No

Sexual Orientation
☐ Lesbian
☐ Gay ☐ Straight
☐ Bisexual ☐ Something Else
☐ Don't Know ☐ Decline to Answer

Recent Hospitalization?
☐ Yes, date: _____
☐ No

Ethnicity:
☐ Non-Hispanic/Latino
☐ Other Hispanic/Latino
☐ Decline Answer

How did you first learn of VIP?
☐ Friend/Patient
☐ Referral
☐ Health Fair/Presentation
☐ VIP Website/Internet
☐ Facebook/Social Media
☐ TV/Radio/Print Media

Gender Identity:
☐ Man ☐ Woman
☐ Trans Man ☐ Trans Woman
☐ Other: _____
☐ Decline to Answer

Highest Level of Education?
☐ Grade School
☐ High School/GED
☐ College ☐ Graduate School

Do you have a lease in your name?
☐ Yes ☐ No
If "No", select which best applies:
☐ Living on the street
☐ Homeless Shelter
☐ Transitional
☐ Doubling Up (not paying rent)
☐ Other

Do you have a current primary care provider that you want to continue to see?
☐ Yes ☐ No

If yes, will you sign a release of information?
☐ Yes ☐ No

Sex Assigned at Birth:
☐ Male ☐ Intersex
☐ Female ☐ Decline to Answer

Employment Status:
☐ Full-time/Part-time
☐ Retired ☐ Unemployed
☐ Disabled/Unable to work

Emergency Contact

Emergency contact name: | Relation to patient:

Emergency contact phone: ( )

VIP COMMUNITY SERVICES

REGISTRATION FORM

CONSENT FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ (Please Print) Date of Birth: _____ (MM/DD/YY)

I hereby authorize the physicians, physician assistants, nurse practitioners and mental health staff of VIP to conduct routine examinations, to obtain specimens, including blood, to perform such tests, and administer treatments, including the injections of pharmaceutical products (medications) and immunizations to myself as may be deemed necessary now and on subsequent days.

I have been informed about the patient's bill of rights and responsibilities.

☐ I do not have an advance directive

☐ I have an executed advance directive

TYPE: ☐ Health Care Proxy ☐ Living Will ☐ Other _____

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you do not have insurance, we are still committed to serving you. We offer a sliding fee scale (based on income) for payment. We also have dedicated staff members available to help patients enroll in insurance plans.

INSURANCE INFORMATION	Do you have health insurance? ☐ Yes ☐ No	
Insurance is through employer ☐ Yes ☐ No		Are you the responsible party? ☐ Yes ☐ No
Insurance carrier:	Policy #:	Group #:
Name of insurance (if different):		Address of Insured:
Sex listed on insured's health insurance plan: ☐ Male ☐ Female		Insured's birth date: / / ☐ All information same as patient

I hereby authorize VIP to furnish medical information to my insurance carrier in accordance with their privacy policy.

By signing this acknowledgement, you (or the guarantor for the patient) accept full responsibility for payment of the services and supplies rendered by VIP.

Name of Patient
Or Responsible Party: _____ (Print) Date: _____

Signature of Patient
Or Responsible Party: _____ Date: _____

Witnessed (VIP Staff): _____ (Print) Date: _____

VIP COMMUNITY SERVICES

REGISTRATION FORM

ANNUAL HOUSEHOLD INCOME				
Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security income, public assistance, veteran's payments, survivor benefits, pension or retirement income				
Interest, dividends, rents Educational assistance, alimony, child support, assistance from outside the household, and other income sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	**Yes**	**No**
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)			Preferred Name	
DOB	Legal Gender	Gender ID	Marital Status	**Marital Status Key:** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address City State Zip				Email Address
Parent/Guardian/ Surrogate (if applicable, please print)			Phone	Preferred Language
Ethnicity **Ethnicity Key:** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown			Race **Race Key:** AIA – Native American or Alaskan ASN – Asian BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial	
Clinic/Office Site Where Vaccine is Administered			Primary Care Physician Address/Phone Number	

	Screening Questionnaire			
1.	Are you feeling sick today?	☐ Yes	☐ No	
2.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
3.	Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐ Yes	☐ No	☐ Unknown
4.	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	☐ Yes	☐ No	☐ Unknown
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? *If yes, how long ago was your most recent vaccine?*	☐ Yes	☐ No	☐ Unknown
6.	Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown
7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Unknown
8.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No	☐ Unknown

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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Pre-Vaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name .....

Age .....

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by ..... **Date** .....

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity 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.

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 insurance plan, Medicare, Medicaid 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.

Recipient/Surrogate/Guardian (Signature) | Date / Time | Print Name | Relationship to patient, if other than recipient

Telephonic Interpreter's ID # | Date / Time

OR

Signature: Interpreter | Date/ Time | Print: Interpreter's Name and Relationship to Patient

Area Below to be Completed by Vaccinator				
Which vaccine is the patient receiving today?				
Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose		
Moderna	□ First Dose	□ Second Dose		
Astra-Zeneca	□ First Dose	□ Second Dose		
Janssen	□ Single Dose			

Administration Site □ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh □ Nasal

Dosage □ 0.5 ml □ 0.25ml

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

□ 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.

Vaccinator Signature: _____

*** Use of this form is optional.**

December 2020