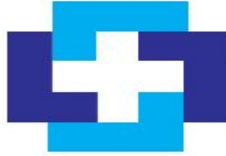

COVID-19 Encounter Form

Date of Service: 4/13/2021

Site# and Address: Loc 1 third party: Holy City Provider: ________________________

Patient Name: ____ DOB: _____________

Address: _____________________________ City: ________________ State: _______ Zip Code: _________

Email Address: _________________________ Phone Number: _______________________

Sex: ______Race: ______Ethnicity: ___________

Product Name: COVID 19 Vaccine **Mcf:** Pfizer-BioNTech **Lot#: ER2613**
NDC#: 59267-1000-1 **Exp Date: 8/2021**

Time Vaccine Administered: ________________ Vaccine Administered by (Print Name): _________________

CPT Codes

Covid-19 Vaccination (Pfizer) 91300____
Administration FIRST Dose 0001A____
Administration SECOND Dose 0002A____

Diagnosis Code

Encounter for Immunization Z23____

NOTES:

Patient here today for Covid-19 Vaccine. Patient given vaccine IM in _____arm. Patient tolerated procedure well after waiting 15 minutes.

provider signature and credentials

Liberty Doctors

Patient Registration Form

PATIENT INFORMATION					
Preferred Pharmacy	*Local pharmacy. This will be used to electronically send your prescriptions when possible.		In order to have access to your Medication History, Liberty Doctors needs your authorization. (PBM consent) Yes □ No □		
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
E-Mail		Date of Birth		Sex	M F
Marital Status	S M D W SEP	SSN		Race	
Preferred Language		Ethnicity			

RESPONSIBLE PARTY INFORMATION (if other than patient)					
Relationship to Patient		*This area to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian, etc…)			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
Date of Birth		SSN		Sex	M F

PRIMARY INSURANCE INFORMATION					
Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

SECONDARY INSURANCE INFORMATION					
Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

Emergency Contact Name		Phone #	
Patient/Legal Guardian Signature		Date	
Liberty Doctors Employee Witness Signature		Date	

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Liberty Doctors (**LD**) to meet your medical needs. We are dedicated to providing the best treatment available. **Carefully read and initial each section and sign and date the bottom.**

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by LD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as to the results of treatments or examinations at LD.

Initials________________

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize LD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to LD. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for LD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize LD to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review LD Notice of Privacy Practices in the office upon request.

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Initials________________

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age __________

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.

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Another product ______			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by ______________________ **Date** __________