SWEETWATER HOSPITAL ASSOCIATION
COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: ______________________ **Birth date:** ___/___/____ **Age:** ______ **Sex:** ☐ Male ☐ Female

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity:** ☐Hispanic ☐Non-Hispanic

Address: ______________________ **City:** ______________________ **State:** _____ **Zip:** ______

Phone: ______________________ **SS#** ______________________

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Question	No	Yes
Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No	☐Yes
If yes, date:______________ Type/Brand of COVID vaccine:______________		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☐Yes
List all allergies: ______________________		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No	☐Yes
Is the person to be vaccinated sick today?	☐ No	☐Yes
Is the person to be vaccinated at least 18 years old?	☐ No	☐Yes
If no, is the person to be vaccinated at least 16 years old?	☐ No	☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No	☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No	☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No	☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

The above information is true to the best of my knowledge.

Signature______________________________ Date______________________

CONDITIONS OF ADMISSION
SWEETWATER HOSPITAL ASSOCIATION
304 CHURCH STREET
SWEETWATER, TN 37874

CONSENT TO TREAT:

I hereby authorize and consent to the care and treatment, including tests, procedures and medical treatments, diagnostic and otherwise, as my physicians, his/her designees, or others of Sweetwater Hospital Association consider to be necessary or appropriate. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination performed at Sweetwater Hospital/Clinics.

I understand that the physicians at Sweetwater Hospital Association, including the attending physician, radiologists, anesthetists, emergency room physicians, pathologists, and other professional practitioners, are not employees or agents of Sweetwater Hospital Association, but are independent contractors who have been granted the privilege of using the facilities for the care and treatment of their patients.

HIV/HEPATITIS TESTING:

I understand that in the event of an employee, student or other health care worker's exposure to my blood/body fluids, it will be necessary for testing for HIV, (AIDS), and hepatitis. I hereby give my permission for the confidential testing.

RELEASE OF INFORMATION:

Unless otherwise specifically limited, I hereby authorize Sweetwater Hospital Association and/or attending physicians to furnish and release to my insurers, to other third-party payers, or to such other persons as may need access for the purposes set forth herein, any and all medical records and information, including those pertaining to medical history, mental or physical conditions, supplies or services rendered or treatment, for the purposes of review, investigation, evaluation of an application, reporting to the Tennessee Immunization Registry, processing of a claim, medical care review, utilization review, quality assurance review, financial, or other audit, or other purposes reasonably related to these purposes.

VALUABLES:

I understand that Sweetwater Hospital Association shall not be liable and is released from any liability for loss or damage of any money or valuables, including but not limited to jewelry, glasses, dentures, documents and other personal articles of value.

FINANCIAL ARRANGEMENTS:

I authorize, direct and assign benefits payable by my insurers to pay directly to Sweetwater Hospital Association and my physicians any and all payable amounts up to the amount of my indebtedness with Sweetwater Hospital Association and my physicians. I understand that my insurance will be filed for amounts due. I understand that I am ultimately responsible for payment of my bill in full regardless of insurance status. I acknowledge that insurance claims are filed as a courtesy to me and any non-payment issues will be my responsibility. I understand and agree that I will promptly pay for services rendered. I understand that should I fail to comply with payment agreements/obligations, my account may be referred for collections and I agree to pay all collection costs including reasonable attorney fees.

I certify that the information given by me in applying for payment under Title XVIII or XIX of the social security act is correct. I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service, or authorize such providers to submit a claim to Medicare for payment on my behalf.

I understand that private room rate differences, should I request a non-medically necessary private room, are my responsibility.

I understand that for many reasons, including pre-admission/pre-certification requirements, insurance and other healthcare payers may not pay part or all of the costs associated with my treatment. In the event this occurs, I understand and agree to make payment in full. I understand that it is my responsibility to provide correct and current insurance information, including John Deere or Cariten Senior Health Medicare HMO coverage. I understand that failure to do so may result in denied claims for which I accept responsibility to pay.

VIDEO SURVEILLANCE:

It is understood that some patient care areas (rooms) are under video surveillance to enhance patient safety. I agree to video surveillance should SHA staff deem it necessary for my safety.

CLINICAL FILMING, RECORDING, AND/OR PHOTOGRAPHING:

I understand the use of clinical filming, recording, and/or photographing is considered routine to patient care and is covered under this general admission consent to treat form. I further understand that I have the right to refuse clinical filming, recording, and/or photographing at anytime and that copies of clinical filming, recording, and/or photographing may be released without further consent for the purposes of treatment, payment, operations and as required by law and regulation. The above does not apply to filming, recording, and/or photographing for non-clinical (non-patient care related topics).

HOSPITAL DIRECTORY: While you are a patient, it is understood that Sweetwater Hospital Association will include your name, location in the hospital, and your general condition in its directories unless you make written objection. (See privacy notice for instructions.)

ADVANCED DIRECTIVE/PATIENT RIGHTS/PRIVACY NOTICE:

I have been given information regarding advanced directives.
I have been offered a copy of patient's rights and responsibilities.

______________________ ______________ ______________________

Patient Signature Date By Relationship

SSN: ______________________

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Witness