

# Pneumonia Consent Form & Vaccine Administration Record

**Pneumonia** -- Pneumonia is inflamed lung tissue and can be caused by many types of germs. Symptoms of pneumonia caused by bacterial germs include a combination of high fever, cough with thick greenish or rust-colored mucus, shortness of breath, rapid breathing, sharp chest pain that is worse with deep breaths, abdominal pain, and severe fatigue. In high-risk groups, pneumonia could lead to further problems and even death

**The Vaccine** -- The pneumococcal polysaccharide vaccine (PPV) protects against 23 types of pneumococcal bacteria, including the types that cause meningitis and bacteremia. An injection of PPV will NOT give you pneumonia. The vaccine is made from a dead virus. We recommend that you remain on site for up to 15 minutes following the injection to monitor for possible vaccine reactions. The vaccine should be taken only one time, but a 5-year booster is recommended in some cases.

**Risks and Possible Side Effects** -- Side effects of PPV are generally mild in adults. These reactions consist of pain and redness where the shot was given. These symptoms may last up to 48 hours. An immediate, presumably allergic, reaction rarely occurs after a PPV vaccination. This probably results from an allergy to some vaccine component.

**Special Precautions** -- Children, pregnant women, and persons with a serious illness should consult their physician before receiving the pneumonia vaccine.

Persons who are allergic to latex should notify the provider prior to receiving this vaccination.

**DO NOT** receive this vaccine if you have an active infection.

**DO NOT** receive this vaccine if you are a Hodgkin's disease patient and it will be fewer than 10 days prior to or during treatment with immunosuppressive drugs or radiation.

**DO NOT** receive this vaccine if you have had a serious reaction to the PPV in the past.

## INFORMATION CONCERNING PERSON TO RECEIVE PNEUMONIA VACCINE:

NAME (please print)	DATE OF BIRTH	AGE	PHONE NUMBER
ADDRESS	CITY	STATE	ZIP
DO YOU HAVE ALLERGIES TO: <input type="checkbox"/> Latex <input type="checkbox"/> Pneumonia vaccine <input type="checkbox"/> Other _____	ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
ARE YOU CURRENTLY GETTING TREATMENT FOR HODGKIN'S DISEASE? <input type="checkbox"/> Yes <input type="checkbox"/> No			
HAVE YOU RECEIVED A PNEUMONIA VACCINES IN THE LAST 5 YEARS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
ARE YOU CURRENTLY A PATIENT AT THIS PHARMACY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
ARE YOU INTERESTED IN RECEIVING MORE INFORMATION ABOUT MEDIHEALTH SOLUTIONS WELLNESS PROGRAMS? <input type="checkbox"/> Yes <input type="checkbox"/> No			

NAME & ADDRESS OF FAMILY PHYSICIAN

## CONSENT:

*I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the pneumonia vaccine as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.*

SIGNATURE OF PERSON RECEIVING or AUTHORIZING VACCINE

DATE

## MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION BELOW:

### Please check one:

- I hereby authorize the pharmacy to bill Medicare Part B on my behalf. I request that payment of authorized Medicare benefits be made to the pharmacy for **the pneumonia vaccine and its administration** as furnished to me by the pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.
- I hereby attest that as of the date indicated above, I am **not** enrolled in Medicare Part B.

## Vaccination Information (office use only)

Merck / Lot #: \_\_\_\_\_ Exp. / /

Dose: 0.5mL Admin. Site: R L Arm Thigh

Amount Paid: \_\_\_\_\_

Signature & Title of Vaccine Administrator: \_\_\_\_\_

Date Administered: \_\_\_\_\_

Medicare Health Insurance Claim Number (HICN): \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Pharmacy is required by law to maintain the privacy of Protected Health Information (“PHI”) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (“Notice”) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

The Pharmacy is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

### **YOUR HEALTH INFORMATION RIGHTS**

You have the following rights with respect to PHI about you:

- ◆ *Obtain a paper copy of the Notice upon request. To obtain a paper copy, contact the pharmacy® manager.*
- ◆ *Request a restriction on certain uses and disclosures of PHI.*
- ◆ *Inspect and obtain a copy of PHI.*
- ◆ *Request an amendment of PHI.*
- ◆ *Receive an accounting of disclosures of PHI.*
- ◆ *Request communications of PHI by alternative means or at alternative locations.*

### **EXAMPLES OF HOW WE MAY USE AND DISCLOSE PHI**

The following are descriptions and examples of ways we use and disclose PHI:

- ◆ *We will use PHI for treatment.*
- ◆ *We will use PHI for payment.*
- ◆ *We will use PHI for health care operations.*
- ◆ *We may disclose PHI about you to our business associates so that they can perform the job we have asked them to, which may include billing you or your third-party payor for services rendered.*
- ◆ *We may communicate with individuals involved in your care or payment for your care.*
- ◆ *We may make health-related communications such as refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.*
- ◆ *We may disclose PHI to the FDA or persons under the jurisdiction of the FDA.*
- ◆ *We may disclose PHI about you as authorized by and as necessary to comply with laws relating to worker's compensation.*
- ◆ *We may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.*
- ◆ *We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.*
- ◆ *We must disclose PHI about you when required to do so by law.*
- ◆ *We may disclose PHI about you to an oversight agency for activities authorized by law such as audits or licensing inspections.*
- ◆ *We may disclose PHI about you in response to a court or administrative order.*

We are permitted to use or disclose PHI about you for the following purposes:

- ◆ *We may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.*
- ◆ *We may release PHI about you to a coroner or medical examiner.*
- ◆ *We may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.*
- ◆ *We may contact you as part of a fundraising effort.*
- ◆ *We may use or disclose PHI about you to notify or assist in notifying a person responsible for your care, such as a family member or personal representative, regarding your location or your general condition.*
- ◆ *We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.*
- ◆ *We may release PHI about you as required by military command authorities.*
- ◆ *We may release PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.*
- ◆ *We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.*
- ◆ *We may disclose PHI about you to a government authority, such as a social services or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.*

### **OTHER USES AND DISCLOSURES OF PHI**

The Pharmacy will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for in this Notice or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

### **FOR MORE INFORMATION OR TO REPORT A PROBLEM**

If you have questions or would like additional information about the Pharmacy's privacy practices, you may contact the privacy officer at 800.445.2244. If you believe your privacy rights have been violated, you can file a complaint with the pharmacy® manager or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.