HEALTH

PATIENT INFORMATION

First Name: _____ Middle:_____ Last:_____

Date of Birth: ____/_____/_____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Address: _____ ZIP: _____

City: _____ State: _____ County: _____

Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____

Alt Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____

Email: _____@_____._____

Contact me by: ____ Secure Message ___Letter ___Home phone ___Email ___ Cell ___ Work

Gender: ___ Male ___ Female Social Security Number: _____-_____-_____

Referring Provider: _____

Preferred Language: _____

Preferred Pharmacy: _____

Allergies:_____

In order to comply with Federal Regulations, we have been directed to collect information from our patients on their race and ethnicity. Please select from the following Federal approved choices:

Race: _____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____Native Hawaiian or Other Pacific Islander ____ White _____ Other

Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino

If Minor or Student:

Mother's Name: _____Date of Birth: _____/_____/_____

Father's Name: _____Date of Birth: _____/_____/_____

Guardian's Name: _____Date of Birth: _____/_____/_____

Address: _____ ZIP: _____

City: _____ State: _____ County: _____

Relationship to patient: _____ Social Security Number ____-____-____

Cell Phone: (_____) _____-_____ Other Phone: (_____) _____-_____

Emergency Contact (not self/parent):

Name _____ Relationship: _____

Address: _____ Zip: _____

Phone: (_____) _____-_____ May we leave a message? YES _____ NO _____

HEALTH

Patient Name: _____DOB: _____

Student/Patient Insurance Information	
Child/Teen has insurance (please X box): YES_____ NO_____	
Name of Insurance Company:	Subscriber's Name:
Group Number:	Subscriber ID:
Phone Number:	

ACKNOWLEDGEMENT AND CONSENT OF RECEIPT OF NOTICE OF PRIVACY

I have reviewed Texas A&M Health Science Center's Notice of Privacy. This policy explains how my medical information will be used and made known. I can get a copy of this document at no cost to me if I ask for it.

Patient requested copy: ____Yes ____No

VACCINE ADMINISTRATION CONSENT AGREEMENT

I, _____, (if minor, for _____) agree to allow immunization(s) provided by Texas A&M Nurses Care Access Network. I am authorizing providers to provide emergency care if needed due to vaccine administration.

I allow Texas A&M Health to submit bills to my insurance company for services provided by Texas A&M Nurses Care Access Network.

I allow my medical information to be released in order to process this assignment on the claim.

I allow payment be made to Texas A&M Health for services provided by them.

I have received and/or accept to the following consent agreements and/or policies:

- **Notice of Privacy**
- **Vaccine Administration Consent Agreement**

_____ _____

Name of Patient (Please Print) *Date*

_____ _____

Signature of Patient or Legal Guardian *Relation to Patient*

TEXAS A&M UNIVERSITY HEALTH

Influenza Vaccine Consent 2022

Patient Name: _____ DOB: _____ AGE: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Do you presently have an illness with or without fever?	☐ YES	☐ NO
Are you allergic to egg or egg products?	☐ YES	☐ NO
Do you have a history of Guillain-Barre Syndrome (A rare, paralytic disorder)?	☐ YES	☐ NO
Are you 65 years of age or greater and would like the recently approved high-dose influenza vaccine?	☐ YES	☐ NO
To your knowledge, are you pregnant?	☐ YES	☐ NO

If you are pregnant, a doctor's authorization is needed before we can administer the flu vaccine.

Consent to Receive Vaccine

I hearby consent to the Influenza vaccination being given to me. I have been given the most current Vaccine Information Statement for Influenza, and I have been given the opportunity to ask questions that were answered to my satisfaction. I understand that I may experience an adverse side effect from the vaccine and hereby relieve such personnel and Texas A&M Health from any and all liability in connection with such injection.

Acknowledgement and Consent of Receipt of Noticy of Privacy

I have reviewed Texas A&M Health Science Center's Notice of Privacy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ YES ☐ NO

_____ _____

Signature Date

Signature of parent/guardian if patient is under 18 years of age: _____

To be filled out by the person administering vaccine*

Date Administered: _____

Manufactured: _____ **Lot #:** _____ **Exp. Date:** _____

Site of Injection: Left Deltoid Right Deltoid Left Thigh Right Thigh

Administered by: _____

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.

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. If you have any questions, please contact our Privacy Office at the phone number or email address listed at the bottom of this notice.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private and secure;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to improve treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies.

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.
We may use or disclose medical information about you without your prior authorization for several other reasons, subject to certain requirements, including for public health purposes, abuse or neglect reporting, disease prevention, health oversight audits or inspections, working with coroners or medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal processes.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In any other situation not covered by this notice, including the use or disclosure of psychotherapy notes or the use or disclosure of medical information about you to sell such information or for marketing purposes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Who will follow this notice?

Texas A&M Emergency Medical Services, Texas A&M College of Dentistry, Texas A&M Clinical Care Practice Plan, and Texas A&M Nurses Care Access Network (CAN) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of the locations of our entities listed above; and
- All employees, medical staff, affiliates, trainees, students, or volunteers of our entities listed above.

While each of these facilities and affiliates operates independently, they may share your health information with each other for coordination of care, treatment, payment, and healthcare operations purposes.

Right to Be Notified of a Breach:
We will notify you promptly in the event that the confidentiality of your information has been breached.

Right to Access and or Amend Your Records:
In most cases, you have the right to look at or get an electronic or paper copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in writing to the Medical Record or Billing Department of the respective entity, as appropriate. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement if we decide not to amend a record.

Right to an Accounting:
You have the right to request a list accounting for any disclosures of your health information we have made, who we shared it with, and why we shared it, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions as required by law.

To request this list of disclosures, indicate the relevant period which must be within the past six years. You must submit your request in writing to the Medical Record or Billing Department of the respective entity, as appropriate.

Right to Request Restrictions:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible.

If you pay all charges associated with the services you received out-of-pocket in full, you may request that your information is not shared with an insurer for purposes of payment or other purposes unrelated to your treatment. We will honor your request unless we are required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

Requests for Confidential Communications:
You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location that you want us to use to communicate with you.

Right to request a paper copy of this notice:
You may receive a paper copy of this notice from us upon request, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Changes to this notice:
We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site.

You can receive a copy of the current notice at any time upon request. The effective date is listed at the end. Copies of the current notice will be available each time you come to receive treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Texas A&M Privacy Office
privacy@tamu.edu
979-845-9853
Toll Free: 833-261-1247