BERGEN GERIATRIC CARE

VACCINATIONS

Dear Caretakers,

In our efforts to provide the best preventive care and avoid adverse outcomes of avoidable infections, we would like to keep your loved ones as updated as possible on their vaccinations. After a review of our vaccination records, we found that is due for:

- ☐ TdaP — tetanus, diphtheria and pertussis
- ☐ Shingles
- ☐ Pneumovax (PPV23)
- ☐ Prevnar (PCV13)
- ☐ Flu

Please review Vaccination Information Statements, created by the CDC to inform patients and families of vaccination benefits and risks.

These information guides can be found at: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

You may fax your consent to (201) 387-2277, or mail your consent to 680 Kinderkamack Road Suite 205, Oradell, New Jersey 07649. Please be mindful that flu season is fast approaching. Although we accept consents at any time during the year, certain vaccinations are most effective before cold and flu season. We appreciate timely responses.

If you have any questions, please do not hesitate to call our office at (201) 387-2003.

Thank you for helping us in our continuing efforts to provide the best care possible,

Dr. Odessa Hoinkis, Dr. Daniel Wilkin and the Bergen Geriatric Care team

680 Kinderkamack Road Suite 205 Oradell NJ 07649 | T 201.387.2003 F 201.387.2277
www.bergengeriatriccare.com

BERGEN GERIATRIC CARE

VACCINATION CONSENT FORM

I, _____ (your name) consent that _____ (patient name) be administered the following vaccinations:

- ☐ TdaP — tetanus, diphtheria and pertussis
- ☐ Shingles
- ☐ Pneumovax (PPV23)
- ☐ Prevnar (PCV13)
- ☐ Flu
- ☐ I refuse all vaccinations

I have reviewed the CDC vaccination information statements and understand the medical benefits and risks associated with the following vaccinations. I am aware that while vaccines can be lifesaving, they also have common side effects such as injection site reaction (pain, swelling, redness), mild fever, shivering, fatigue, headache, muscle and joint pain. Vaccines also have risks including discomfort, swelling, bruising, infection and allergic reaction. I am aware that there may be inflammation at the site of an intramuscular, subcutaneous and/or intradermal injection (phlebitis), which may cause prolonged discomfort and may require special care.

I am aware that these vaccinations are not necessarily covered by Medicare or my insurance plan. I recognize that I am responsible for any deductible or co-pay at the time of service as described by my insurance policy. In the event that my insurance does not cover the previously mentioned vaccines, I am aware that I am responsible for full payment, and hereby guarantee payment in full to Bergen Geriatric Care for all charges for services rendered and/or charges exceeding third party payments (except where prohibited by law or under contract). I also authorize Bergen Geriatric Care to release to government agencies, insurance carriers and others who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and challenge denials of medical necessity. I hereby assign all amounts payable for services rendered to Bergen Geriatric Care. I understand that this constitutes a waiver of confidentiality under 42C>F>R part 2 (drug and alcohol records) and N.J.S.A. 26:5c-1et seq. (FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the propose for which it is given.

I give my free and voluntary consent for the vaccination. I understand that no guarantee can be promised. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in immunization. I agree to notify this office if I suspect a change in my condition.

Signature _____ Date _____

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BERGEN GERIATRIC CARE

RESPECTING AND ENSURING THE WISHES OF OUR PATIENTS

Dear Caretakers,

During routine chart audits, it has come to our attention that your loved one is missing:

- ☐ Advanced Directives
- ☐ Health Care Proxy

Understandably, matters relating to end of life and incapacity are difficult to discuss. However, it enables physicians and clinical care staff to provide the type of health care that an individual expresses he or she would prefer. If a loved one is unable to make such decisions for him or herself, our goal is to provide care that honors the wishes of our patient.

We encourage you to discuss your feelings and beliefs about these subjects with all parties involved in health care decisions. Candid conversation can significantly reduce the chance of disagreements occurring between those who care for a loved one, and may relieve loved ones of some of the heavy burdens of decision making, while lending additional assurance that patient's wishes will be respected.

An Advance Health Care Directive (Advance Directive) is a document in which a patient gives instructions about his or her health care if, in the future, they are unable to speak for themselves.

A Health Care Proxy is someone a patient appoints to make health care decisions in the event that he or she can no longer do so.

We have included blank versions of these documents for you to review and complete. For more information, please visit: http://www.state.nj.us/health/advancedirective/ad/what-is/.

If you already have these documents, please fax them to (201) 387-2277, or mail them to 680 Kinderkamack Road Suite 205, Oradell, New Jersey 07649 Attn: Bergen Geriatric Care.

If you have any questions, please do not hesitate to call our office at (201) 387-2003.

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