Scheduling Your Initial Vaccine Appointment
Scheduling Link for Eligible Individuals

https://vaccine.coronavirus.in.gov/
Select your group

- Select the group you belong to
- Click the box confirming eligibility
- Click at the bottom to begin scheduling an appointment
Confirm eligibility

- Check that you have read Attestation statement
- Note that there may be a delay for this to appear
- You must be a resident of Indiana
- May need to click on twice

Select “Schedule an Appointment”
Search for a site

Enter your ZIP code to find a list of vaccination sites close to you.

You’ll also be asked if this is your first shot.
1. BAPTIST HEALTH FLOYD
1850 STATE ST
NEW ALBANY, IN 47150

Schedule your appointment!
Choose your appointment

Use the < and > arrows to move from week to week or can select the drop-down arrow.

Select the time that works best for you and click “Select This Time.”
Patient Information

Who is this appointment for?

First Name

Last Name

Birth Date

Gender

Yes / No

Contact Preference

Email

Text message and auto-dialed call

Telephone Number:

Submit Patient Information

Complete your information, review policy statement, and select “Submit Patient Information”
Confirm Your Appointment

- Review your information
- Edit any information that is incorrect.
  - Please note that the system does not accept hyphens; please include a space as a substitute.
  - Please note that the system does not accept accents and they may need to be removed.
- Select “Confirm Appointment”
You are not done!

You can either:
Select “Continue to Registration”
OR
Complete the registration from the LINK sent to you via TEXT or EMAIL (based on your selection above)

It is imperative that you complete the registration steps via one of the ways above to make sure that your vaccination appointment moves quickly the day you vaccinate!
Select “Continue”
Input Your Information

➢ Enter Your Information
➢ Click Save
➢ Repeat

The Insurance carrier starts to auto-populate once you type.

BY LAW, NO PATIENT WILL BE CHARGED FOR A COVID19 VACCINATION.
Verify Your Information

- Verify Information
- Edit any information that is incorrect
- “Submit Information”
Input your employment information

- Select “Continue” to enter demographic information
- Select your response
- Click “Continue”
- Repeat
Input your employment information

✓ Answer employment information
✓ Click “Submit”
Health Habits

Tell us about your health and lifestyle
The information you provide will help us better understand the virus and how it affects people.

Select “Continue”

Input information

Select “Submit”
Consents

**PATIENT CONSENT FOR COVID-19 VACCINATION**

**Explanation of Vaccination:**
Vaccination for SARS COVID-19 is an intramuscular injection. Intramuscular injections are administered at a 90 degree angle to the skin, preferrably into the deltoid muscle of the upper arm. Risks associated with this vaccination include mild side effects, such as fever, injection site pain, headache, muscle aches and fatigue, and a small percentage may still be vulnerable even after receiving the vaccine. This vaccine will require two (2) doses to work, and you will need to return for the second dose within the recommended time frame. This vaccine is presently available under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).

**PATIENT'S CONSENT**
I, the undersigned, certify that I am at least eighteen (18) years of age, have been informed about the vaccine purpose, procedure, and risks, and I have elected to receive. I understand this vaccination may be subject to reporting to a health information exchange or an immunization registry, who may share my vaccination information with others, and to my healthcare providers, for treatment purposes or as otherwise permitted by law. I have had the opportunity to have all my questions addressed before receiving the vaccine. I voluntarily consent and agree to receive the vaccination for COVID-19.

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:**
I authorize the Indiana State Department of Health to disclose protected health information about me to my employer as described below:

**Description of Information to be released:** COVID-19 Vaccination Results

**Purpose of Release:** To ensure patient receives documentation of the COVID-19 vaccination.

Use and disclosure may be withdrawn. AUTHORIZATION: I understand that once the authorized information has been disclosed, it may not longer be protected by the HIPAA Privacy Rule. I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization. I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on this request. Written revocation will be effective upon receipt by the Indiana State Department of Health at 2 N. Meridian St., Indianapolis, IN 46204. Without my express revocation, this request will automatically expire one hundred and eighty (180) days after the date of signature.

Select “Continue”
Select “Accept”
Select “Continue”
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.

Use and Disclosure of PHI

Authority is Not Required. Disclosures of PHI may be made by the Indiana Department of Health without patient authorization when those disclosures are made:

1. Required by law;
2. Required for public health activities (e.g., communicable disease investigations);
3. Pursuant to a court order; or
4. Related to specialized government activities.

Your Rights Regarding Your Health Information:

You have the following rights regarding your health information as created and maintained by this agency:

1. You have a right to request and receive a copy of this privacy notice. You have the right to request a paper copy of this notice at any time, even if you agree to receive it electronically (by e-mail).
2. Requests to view medical records should be made to your health care provider, for example, your local health department or physician. The Indiana Department of Health is an indirect treatment provider. Any requests made directly to the Indiana Department of Health will be referred to the Indiana State Department of Health Privacy Officer.

Consents

✓ Review Privacy Practices
✓ Select “Accept”
✓ Select “Continue”
Consents

✓ Type your name
✓ Click “Sign Forms”
✓ Make sure the box is checked that you agree to participate

Please enter your name and relationship to the patient to acknowledge that you have reviewed and agreed the agreements presented to you. By signing this agreement electronically (rather than in hardcopy), my electronic signature will have the same legal effect as a handwritten signature.

Name
Patricia

Relationship to Patient
Patient

I agree to participate in the COVID-19 vaccination and acknowledge the risks associated with it. I also understand how my medical information may be used and disclosed, and how I can get access to it as described on the previous page.

Sign Forms
You are done!!
Troubleshooting

Q. I received a “Enter your Invitation Code” screen. What should I do?
A. Make sure you are using Firefox or Chrome on your computer or smartphone to access the link. It will not work in Internet Explorer/Edge (Microsoft Browsers). Re-enter the scheduling link OR click the “I don’t have an invitation code” button.

Q. My browser timed out, what do I do?
A. Re-enter and re-try the scheduling link in a few minutes.

Q. I’m getting a different error screen. What should I do?
A. Make sure you are using Chrome or Firefox, even on your smartphone. It will not work in Internet Explorer/Edge (Microsoft Browsers). Please re-enter and re-try the scheduling link.
Need assistance?

Please call 211 if you need to cancel or reschedule your vaccination appointment due to an unexpected emergency.