Scheduling Your Initial Vaccine Appointment

Scheduling Link for Eligible Individuals

https://scheduling.coronavirus.in.gov/vaccine

Troubleshooting

Q. I received a "Enter your Invitation Code" screen. What should I do?

A. Make sure you are using Firefox or Chrome 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.

Check for your facility

You will be provided a list of facilities.

If you do not see your employer, select "My employer is not listed. I will schedule my vaccine at a nearby facility."

Indiana Healthcare Worker Vaccine Program

Indiana Healthcare workers are invited to schedule a vaccine appointment where they work or near their home.

If your employer is listed below, you can get vaccinated at work

Employers

If you don't see your employer, select "My employer is not listed"

- ◯ ADAMS MEMORIAL HOSPITAL
- ◯ ASCENSION ST VINCENT EVANSVILLE
- ◯ ASCENSION ST VINCENT INDIANAPOLIS
- ◯ ASCENSION ST VINCENT KOKOMO
- ◯ ASCENSION ST VINCENT NOBLESVILLE
- ◯ BAPTIST HEALTH FLOYD
- ◯ BEACON ELKHART GENERAL
- ◯ CAMERON MEMORIAL COMMUNITY HOSPITAL
- ◯ CLARK MEMORIAL HOSPITAL

Select Your Facility

WITHAM HEALTH SERVICES LEBANON ST

My employer is not listed. I will schedule my vaccine at a nearby facility.

Healthcare Employment Attestation

I certify that I have received the link for registration the initial phase of COVID-19 vaccination because I am a healthcare worker who has face-to-face interactions with patients or contact with infectious material. I have received the registration link directly from the Indiana Department of Health, my employer, a healthcare association or a professional licensing agency. A facility or employee ID, or other verification of my healthcare role, will be required. I am a resident of Indiana or work in a healthcare facility in Indiana.

Yes

No

Schedule a Vaccine

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

Select “Schedule a Vaccine”

Check for your facility

Enter your home zip code to find your vaccination site

Enter your home zip code

Search

If your employer is not available, you can receive a vaccine from a nearby facility.

Enter your home zip code to find your vaccination site

46151

Search

You can do a search for a site near you where you can get a vaccine.

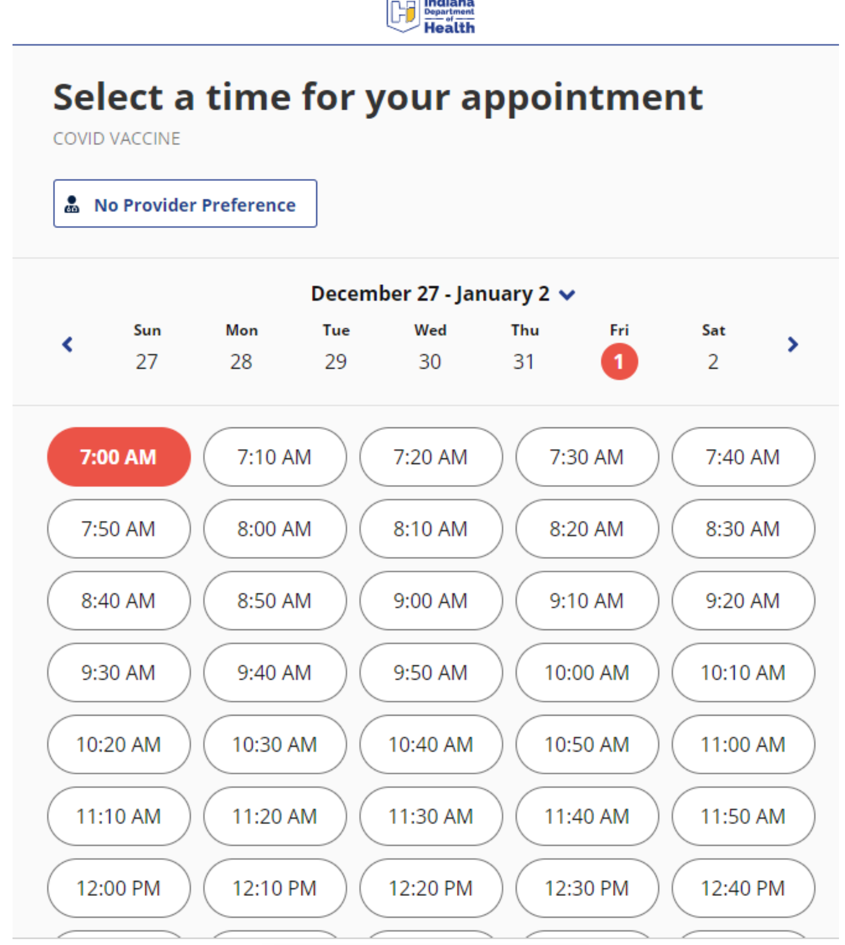
1. BAPTIST HEALTH FLOYD

1850 STATE ST
NEW ALBANY , IN 47150

Schedule an Appointment

Schedule your appointment!

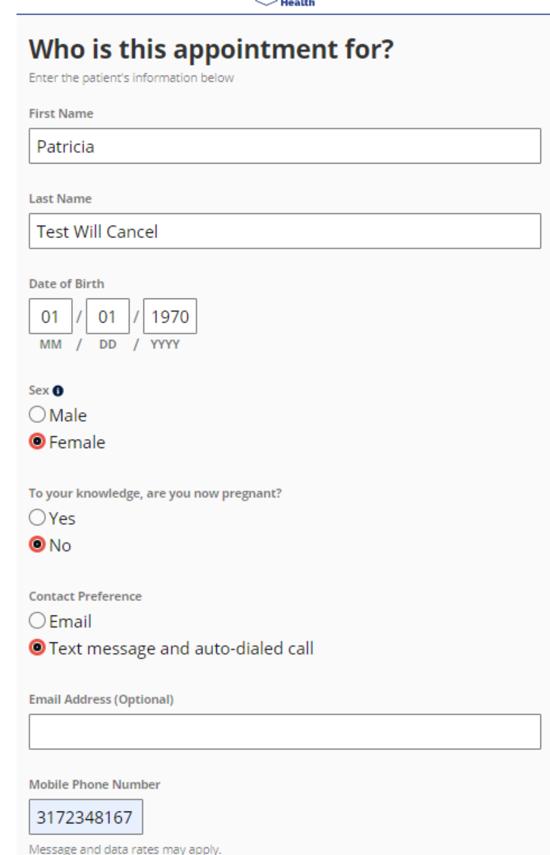
Choose your appointment



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?

Enter the patient's information below

First Name

Patricia

Last Name

Test Will Cancel

Date of Birth

01 / 01 / 1970

MM / DD / YYYY

Sex

Male

Female

To your knowledge, are you now pregnant?

Yes

No

Contact Preference

Email

Text message and auto-dialed call

Email Address (Optional)

Mobile Phone Number

3172348167

Message and data rates may apply.

Use and Disclosure of Protected Health Information (PHI) for Payment, Treatment and Health Operations:

1. Required by law;
2. Required for public health activities (example: reporting positive test results for communicable diseases);
3. Pursuant to a court order; or
4. Related to specialized government activities, such as national security.

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).

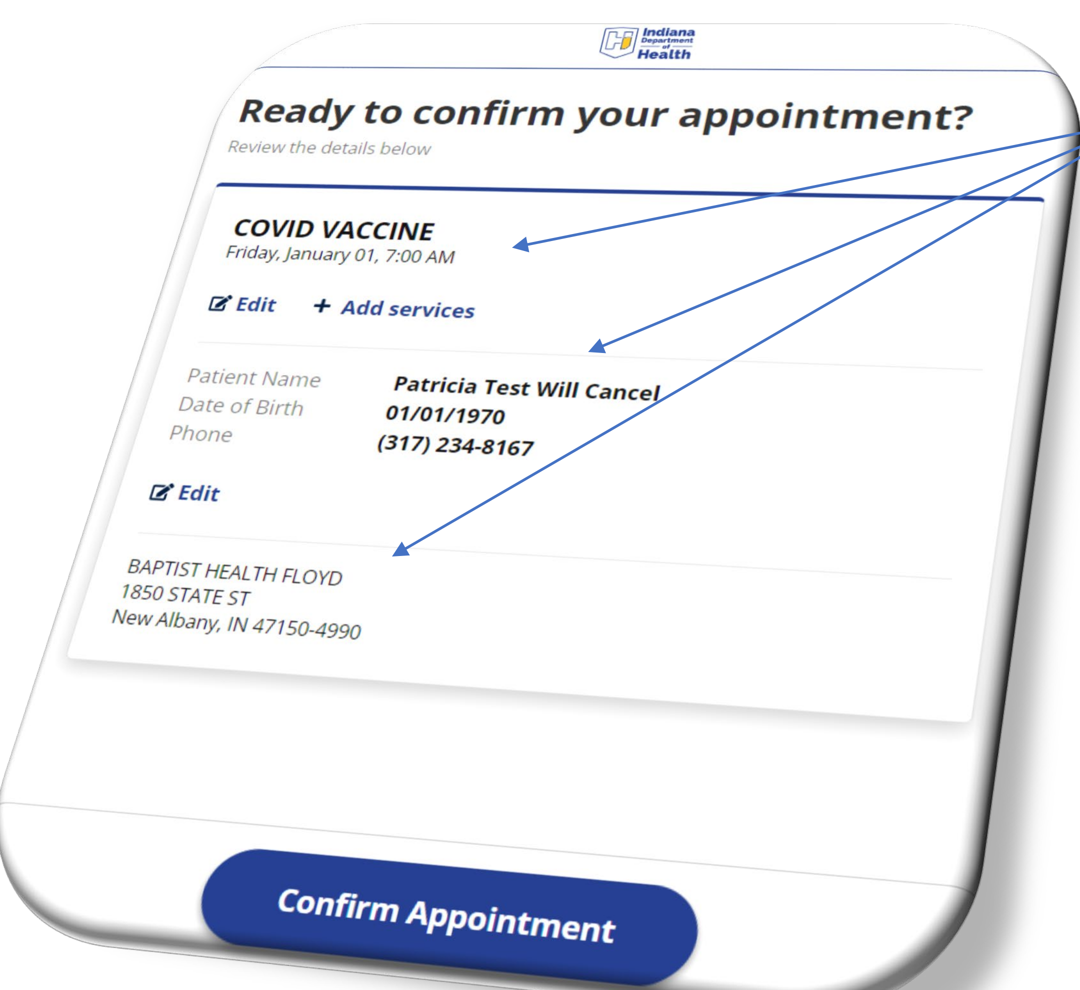
Complaints

- Privacy Officer
  Office of Legal Affairs
  Indiana State Dept. of Health
  2 N. Meridian St.,
  Indianapolis, IN 46204
  317-233-7655
- Indiana Attorney General
  Consumer Protection Division
  302 W. Washington St., 5th Floor
  Indianapolis, IN 46204
  317-232-6330
  800-382-5516
- US Dept. Health & Human Services
  Office for Civil Rights – Region V
  233 N. Michigan Ave. – Suite 240
  Chicago, IL 60601
  312-866-2359

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!

Your appointment is confirmed!

Check in at the front desk in the clinic when you arrive. Please bring your ID and insurance cards with you to your appointment.

Register early to save time at check in and get estimates for your services.

Continue to Registration

COVID VACCINE

Friday, January 1, 7:00 AM

Add to Calendar

BAPTIST HEALTH FLOYD

1850 STATE ST
New Albany, IN 47150-4990

Get Directions

Select "Continue"

Begin Registration

a little bit more information about the patient before their appointment.

- ~~*Schedule appointment*~~
- 2 **Provide contact information and insurance**
- 3 Provide patient demographics
- 4 Describe your health habits
- 5 Sign consent forms

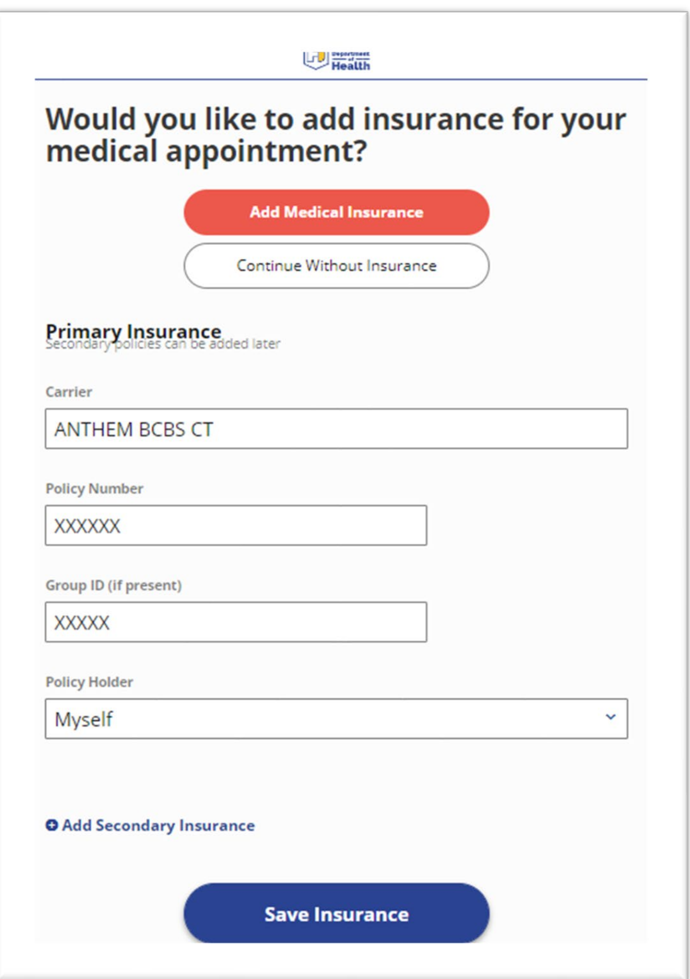
Continue

Input Your Information

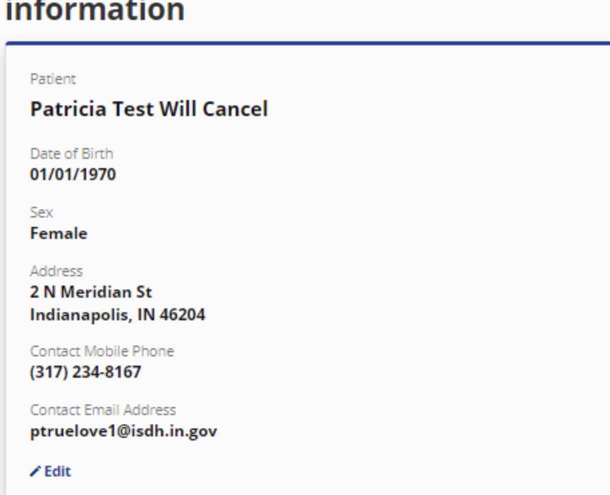
- Enter Your Information
- Click Save
- Repeat

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

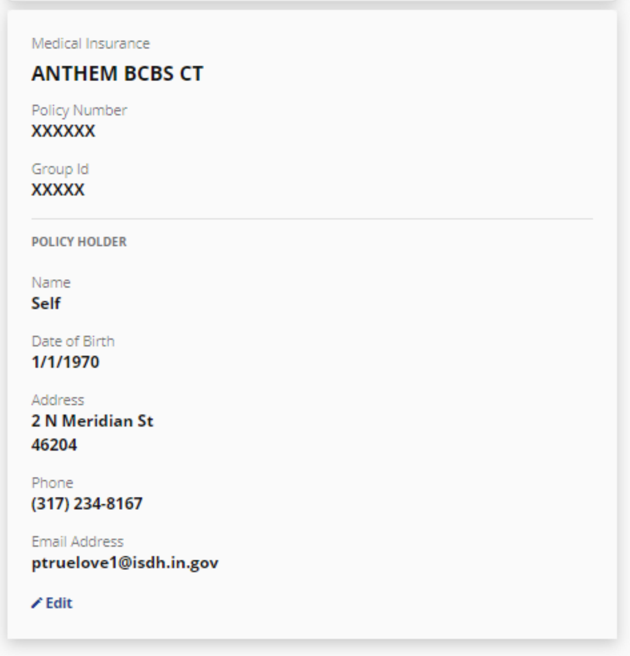
BY LAW, NO PATIENT WILL BE CHARGED FOR A COVID19 VACCINATION.



Verify Your Information

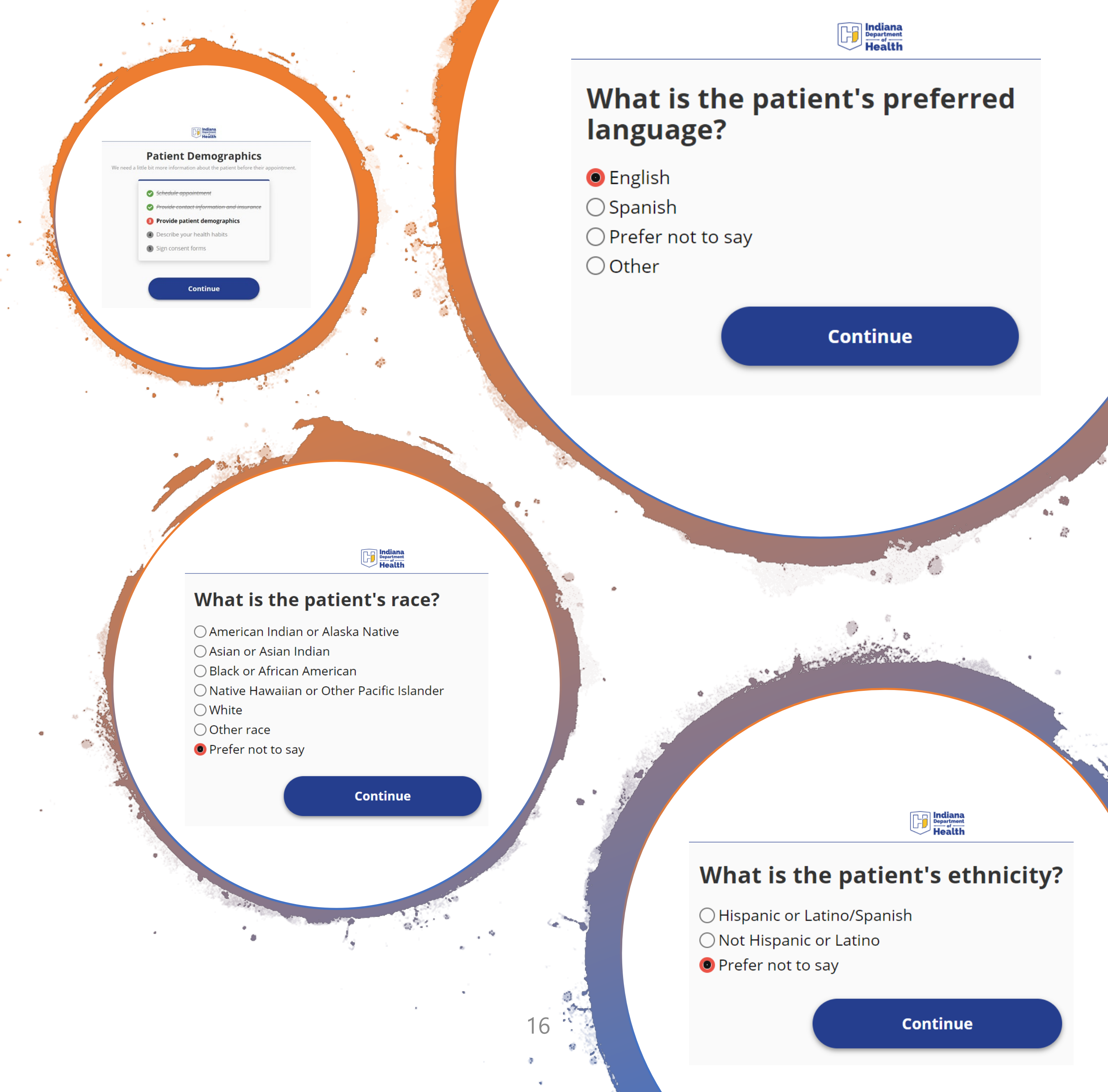


- Verify Information
- Edit any information that is incorrect
- "Submit Information"



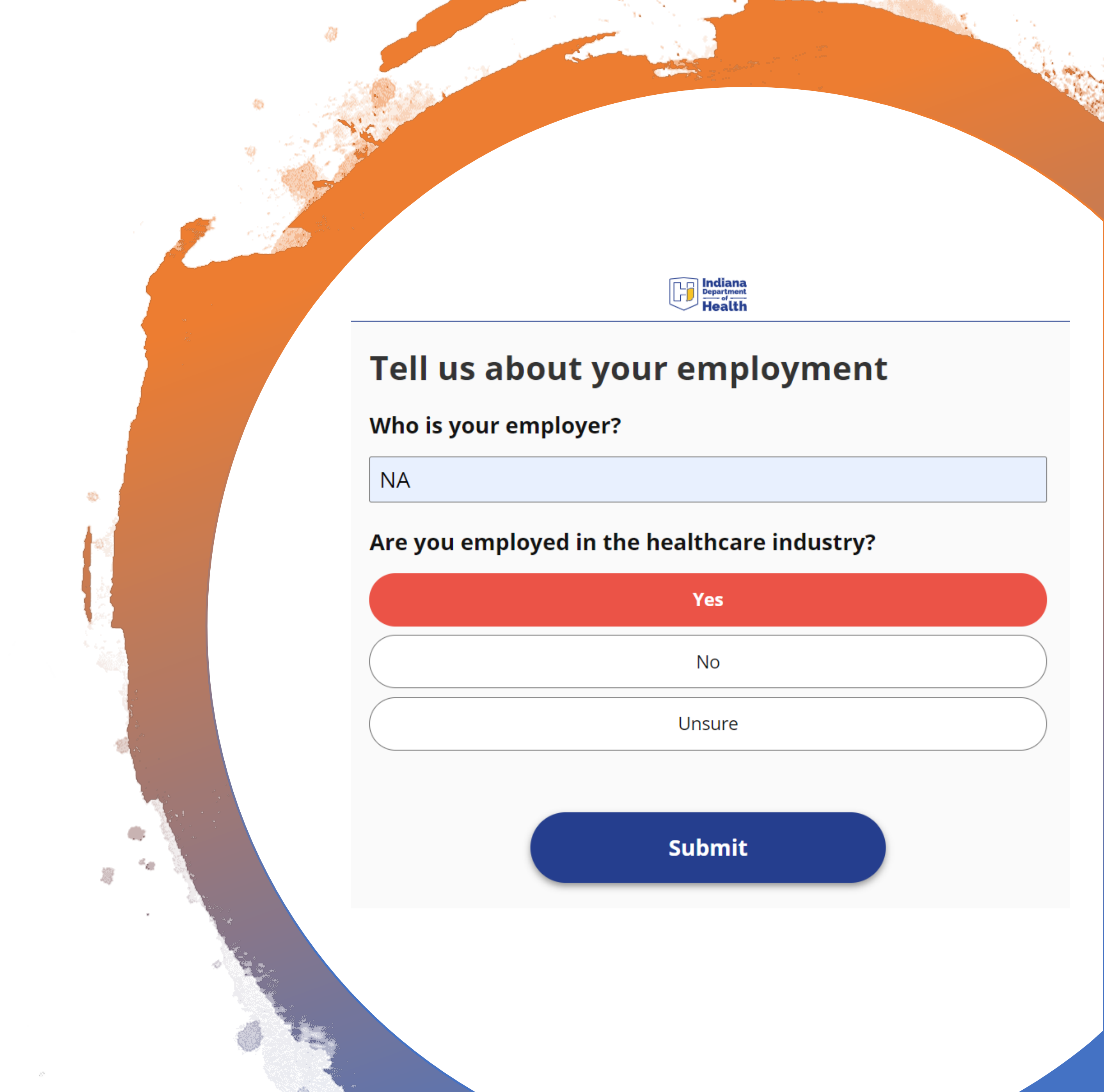
Input your employment information

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



Input your employment information

- ✓ Answer employment information
- ✓ Click "Submit"



Health Habits

Indiana Department of Health

Tell us about your health and lifestyle

The information you provide will help us better understand the virus and how it affects people.

- ~~Schedule appointment~~
- ~~Provide contact information and insurance~~
- ~~Provide patient demographics~~
- 4 **Describe your health habits**
- 5 Sign consent forms

Continue

✓ Select "Continue"

Have you ever had a serious reaction after receiving a vaccination?

Yes

No

✓ Input information

Add Risk Factor: Please check any that apply

- ☐ Obesity
- ☐ Over the age 65
- ☑ Diabetes
- ☐ Chronic Kidney Disease
- ☐ COPD
- ☐ Serious Heart Condition
- ☐ Sickle Cell Disease
- ☐ Other

Add reason for vaccination: Please check any that apply

- ☑ Health Care Worker
- ☐ Long Term Care Employee
- ☐ Long Term Care Resident

Submit

✓ 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, preferably 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 health care 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.

Indiana Department of Health

Sign Consent Forms

Please review the statements on the following screens and check the boxes to indicate that you have received and understand.

- ~~Schedule appointment~~
- ~~Provide contact information and insurance~~
- ~~Provide patient demographics~~
- ~~Describe your health habits~~
- 5 **Sign consent forms**

Continue

- ✓ Select "Continue
- ✓ Review the Consent
- ✓ Select "Accept"
- ✓ Select "Continue"

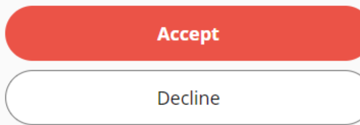
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

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.



Continue

Consents

✓ Review Privacy Practices

✓ Select "Accept"

✓ Select "Continue"

Notice of Privacy Practices

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

Copies of any revised Notices will be available to y
at any time, you have questions or concerns about tl
this Notice or about our agency's privacy policies, p
practices, you may contact our agency Privacy Offi
contact information later in this Notice.

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The Indiana Sta
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health informat
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operations prov
This agency is r
privacy practice
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described in thi
of the Notice cu
change our priv
the new Notice
maintain. We al
your unsecured

Use and Disclosure of Protected Healtl
(PHI) for Payment, Treatment and I
Operations:

1. The Indiana State Department of Health is usi...
information as part of its public health emergency response
activities.
2. The Indiana State Department of Health may use PHI for
healthcare operations including, without limitation, in the
examples below:
   a. Documenting and tracking COVID-19 vaccinations
   throughout Indiana.
   b. Providing training programs for students, trainees, and
   professional staff.
   c. Providing required documentation to certifying and
   licensing agencies.
3. The Indiana State Department of Health may use PHI for
treatment purposes including, without limitation,
below:
   a. Administering or assisting with the admini
   vaccinations.
   b. Administering or assisting with the adminis
   SARS-CoV-2 vaccinations.
4. The Indiana State Department of Health may use
payment purposes including, without limitation,
below:
   a. Billing for payment or reimbursement for a
   SARS-CoV-2 vaccinations.
5. Certain PHI related to communicable diseases is confidential
under Indiana law and any use or disclosure of that information
more restrict
6. We are not a
purposes unl
7. Other uses a
authorization
writing, exce
happened or
obtaining ins

Use and Disclosure of PHI
Authorization is Not Requ

Disclosures of PHI may be made by the Indiana
Health without patient authorization when those

1. Required by law;
2. Required for public health activities (examp
test results for communicable diseases);
3. Pursuant to a court order; or
4. Related to specialized government activitie
security.

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 State Department of Health is an indirect
treatment provider. Any requests made directly to the Indiana
State Department of Health will be referred to the Indiana State
Department of Health Privacy Officer.

the information was not created by us, is not part of the
information you are allowed to review or copy, or if we decide
the personal health information is accurate and complete.

5. You have the right to request that we not release your personal
health information, i
release it for reasons
to honor your reques
request if:
   a. The disclosure
   operations, but
   b. The protected
   care item or se
   provider in full
6. You have the right to request and receive a v
disclosures of your health information. You r
disclosures we made up to six years before y
prior to the effective date of this Notice. This
the date of the disclosure, the name (and add
the person or organization receiving the info
description of the information disclosed and
disclosure. All requests for an accounting of
made in writing. Please contact the Indiana S
Health Privacy Officer as described below to
request an accounting of disclosures from th
Department of Health Laboratories program,
Response program, or any other program.
7. You have the right to request that we contact
personal health matters in a certain way or at
For example, you can request that we only c
by e-mail. We will review and accommodate
To request a special method for us to contact
personal health information, you must call o
Officer at the address or phone number in th
at the end of this notice.

Complaints

If you believe that we have violated your privacy rights or our health information practices, you may file a complaint with our Privacy Officer or the U.S. Department of Health and Human Services or the Indiana State Attorney General's office. Any person who files a complaint will not be retaliated against for filing a complaint.

- Privacy Officer
  Office of Legal Affairs
  Indiana State Dept. of Health
  2 N. Meridian St.,
  Indianapolis, IN 46204
  317-233-7655
- Indiana Attorney General
  Consumer Protection Division
  302 W. Washington St., 5th Floor
  Indianapolis, IN 46204
  317-232-6330
  800-382-5516
- US Dept. Health & Human Services
  Office for Civil Rights – Region V
  233 N. Michigan Ave. – Suite 240
  Chicago, IL 60601
  312-866-2359

Acknowledge

Decline

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 ackowledge 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!!

Registration Complete!

Your information has been updated, and you're all set for your appointment.

Finish and Log Out

COVID VACCINE

KRISTINA BOX

Friday, January 1, 7:10 AM

Add to Calendar

Price With Insurance: $0.00

Revisit Patient Information

Revisit Patient Demographics

Revisit Consent Forms

BAPTIST HEALTH FLOYD

1850 STATE ST New Albany, IN 47150-4990

Get Directions

Please call within 48 hours if you need to reschedule or cancel your appointment

Need assistance?

Contact the HelpDesk at:

https://eportal.isdh.in.gov/C19VAXPublic/