

PATIENT INFORMATION

Legal last name:	Legal first:	Middle:	Today's date: / /
Chosen first name (if different):			Social Security number: - -
Billing address:		Apartment #:	Cell phone number: ()
City:	State:	Zip Code:	Home phone number: ()
E-Mail Address for Patient Portal: *Must be 18 years of age or older*			Work phone number: ()

Preferred Pronoun: He She They Ze A pronoun not listed No pronoun preference

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank You.

Preferred Spoken/Written Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____ Language interpretation services needed? <input type="checkbox"/> No <input type="checkbox"/> Yes, language: _____	Race: *Select all that apply* <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black and/or African American <input type="checkbox"/> White/Caucasian Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Filipino <input type="checkbox"/> Other <input type="checkbox"/> Japanese Native Hawaiian/Pacific Islander: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to Answer	Ethnicity: <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Dominican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic/Latino <input type="checkbox"/> Decline to Answer Housing Status: <input type="checkbox"/> Stable Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Decline to answer If homeless, select which best applies: <input type="checkbox"/> Street <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up (not paying rent)	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
			Migrant Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Orientation <input type="checkbox"/> Lesbian <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Something Else <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Decline to Answer	Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Female <input type="checkbox"/> Decline to Answer	Gender Identity: <input type="checkbox"/> Male/Man <input type="checkbox"/> Female/Woman <input type="checkbox"/> TransMale/TransMan <input type="checkbox"/> TransFemale/TransWoman <input type="checkbox"/> Genderqueer/Gender nonconforming <input type="checkbox"/> Something Else <input type="checkbox"/> Decline to Answer	How did you first learn of Callen-Lorde? <input type="checkbox"/> Friend/Patient <input type="checkbox"/> Referral <input type="checkbox"/> Health Fair/Presentation <input type="checkbox"/> Callen-Lorde Website/Internet <input type="checkbox"/> Callen-Lorde Brochure/Ad <input type="checkbox"/> Facebook/Social Media <input type="checkbox"/> TV/Radio/Print Media
			Do you have a non Callen-Lorde primary care provider that you want to continue to see? <input type="checkbox"/> Yes <input type="checkbox"/> No

Income

Anticipated annual household income for this year: _____ Total # of people living in household, including yourself: _____

Emergency Contact

Emergency contact name: _____ Emergency contact phone: () _____

INSURANCE INFORMATION Insurance is through an employer

If you do not have health insurance, please complete the Application for Sliding Discount to apply for a sliding scale discount based on your income.

Insurance carrier: _____ Policy #: _____ Group #: _____

Sex listed in insured's health insurance plan: Male Female Insured's birth date: / /

Name of insured (if different): _____ Address of insured: Same as Patient

I verify that the above information is correct to the best of my knowledge.

X _____ / /
Patient Signature Date

PATIENT CONSENT FORM

ALL PATIENTS: PLEASE READ AND SIGN AT #1 AND #2 PRIOR TO FIRST VISIT

1) CONSENT FOR TREATMENT:

I, _____ (**please print name**) am voluntarily seeking medical care and treatment from Callen-Lorde Community Health Center ("Callen-Lorde") and give permission to the medical, mental, and oral health staff of Callen-Lorde to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

X _____ /_____/_____
Patient Signature *Date*

X _____ /_____/_____
Guardian/Parent Signature *Date*

2) CONSENT TO BILL:

- ✓ If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Callen-Lorde's Patient Financial Policy;
- ✓ If my insurance is accepted, I authorize payment of benefits to Callen-Lorde or will reimburse Callen-Lorde if I am paid directly by my carrier;
- ✓ I hereby authorize that Callen-Lorde may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;
- ✓ I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;
- ✓ I understand that my insurance may not cover all charges deemed medically necessary by Callen-Lorde;
- ✓ I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

X _____ /_____/_____
Patient Signature *Date*

X _____ /_____/_____
Guardian/Parent Signature *Date*

3) Patient Rights and Responsibilities:

- ✓ I have received a copy of the **Callen-Lorde Patient Rights and Patient Responsibilities**

X _____ /_____/_____
Patient Signature *Date*

X _____ /_____/_____
Guardian/Parent Signature *Date*

**ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTICE PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Callen-Lorde **HIPAA Notice of Privacy Practices**.

Patient Name (please print name)

X _____
Patient Signature

Date

OR

Personal Representative Name (please print name)

X _____
Signature of Personal Representative

Date

Authority of Personal Representative to Sign for Patient (**check one**):

- Parent Guardian Power of Attorney Other: _____

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT

-----*Staff Use Only*-----

I tried to obtain written Acknowledgement by the noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgment.
- ___ A communication barrier prevented us from obtaining acknowledgement.
- ___ The individual was unwilling to sign.
- ___ Other: _____

Staff Member Name (please print name)

X _____
Staff Member Signature

Date

Name _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Total annual income is \$ _____ **Number of dependents (Including Self)** _____

Please check which financial documents you are providing:

- | | |
|---|--|
| <input type="checkbox"/> Pay Stub | <input type="checkbox"/> Letter of Unemployment/Check Stub |
| <input type="checkbox"/> Tax Form | <input type="checkbox"/> Letter of Employment |
| <input type="checkbox"/> Bank Statement | <input type="checkbox"/> Other (please explain): _____ |

If you are unable to provide documentation, check all that apply:

- I do not have documentation today.
- I get paid in cash
- I do not get paychecks or pay stubs
- I do not earn income
- Other reason: _____

*****If your annual income does not match your documents, please explain why:**

- I am employed for only part of the year (please explain): _____
- My income changes from month to month (please explain): _____
- Other reason (please explain): _____

I certify that I have provided all of my income information and that all of the above information is true and correct. I understand that this information is required to fulfill grant reporting purposes and will be used to determine eligibility for the Income Based Sliding Fee Scale at Callen-Lorde if I am uninsured. I also understand that if I have intentionally misrepresented my income, I will be asked to repay any discounts I have been given, and may lose my eligibility for discounts in the future. I understand that false information may also lead to discharge from Callen-Lorde.

You may need to meet with an Insurance Navigator to determine eligibility before receiving a discount for some services.

I decline to provide my income information. I understand that this decision may _____
affect my ability to receive sliding scale discounts for services I receive. (Initial)

Signature _____ **Date** _____

To apply this income to previous service dates, the effective date is: _____