CALLEN LORDE COMMUNITY HEALTH CENTER

REGISTRATION FORM

#:_____

PATIENT INFORMATION

Legal last name: | Legal first: | Middle:

Today's date: / /

Social Security number: — —

Chosen first name (if different):

Date of Birth: / /

Billing address:

Apartment #:

City: | State: | Zip Code:

Cell phone number: ( )

Home phone number: ( )

Work phone number: ( )

Which is your primary contact number?
- ☐ Cell
- ☐ Home
- ☐ Work

E-Mail Address for Patient Portal:
Must be 18 years of age or older

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:
- ☐ English ☐ Spanish
- ☐ American Sign Language
- ☐ Other: _____

Language interpretation services needed?
- ☐ No
- ☐ Yes, language: _____

Sexual Orientation
- ☐ Lesbian
- ☐ Gay ☐ Straight
- ☐ Bisexual ☐ Something Else
- ☐ Queer ☐ Decline to Answer

Gender Identity:
- ☐ Male/Man
- ☐ Female/Woman
- ☐ TransMale/TransMan
- ☐ TransFemale/TransWoman
- ☐ Genderqueer/Gender nonconforming
- ☐ Something Else
- ☐ Decline to Answer

Race: *Select all that apply*
- ☐ American Indian/Alaska Native
- ☐ Black and/or African American
- ☐ White/Caucasian

Asian:
- ☐ Asian Indian
- ☐ Chinese ☐ Korean
- ☐ Filipino ☐ Vietnamese
- ☐ Japanese ☐ Other

Native Hawaiian/Pacific Islander:
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Decline to Answer

Sex Assigned at Birth:
- ☐ Male ☐ Intersex
- ☐ Female ☐ Decline to Answer

Ethnicity:
- ☐ Non-Hispanic/Latino
- ☐ Dominican
- ☐ Cuban
- ☐ Mexican, Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino
- ☐ Decline to Answer

Housing Status:
- ☐ Stable Housing
- ☐ Homeless
- ☐ Decline to answer

If homeless, select which best applies:
- ☐ Street
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up (not paying rent)

Veteran? ☐ Yes ☐ No

Migrant Worker? ☐ Yes ☐ No

How did you first learn of Callen-Lorde?
- ☐ Friend/Patient
- ☐ Referral
- ☐ Health Fair/Presentation
- ☐ Callen-Lorde Website/Internet
- ☐ Callen-Lorde Brochure/Ad
- ☐ Facebook/Social Media
- ☐ TV/Radio/Print Media

Do you have a non Callen-Lorde primary care provider that you want to continue to see? ☐ Yes ☐ 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**

CALLEN LORDE
COMMUNITY HEALTH CENTER

MR#:_____

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

3) Patient Rights and Responsibilities:

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

X_____	____/____/____	**X**_____	____/____/____
Patient Signature	***Date***	***Guardian/Parent Signature***	***Date***

CALLEN LORDE
COMMUNITY HEALTH CENTER

MR#:_____

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: _____

_____ **X**_____ _____
Staff Member Name (please print name) ***Staff Member Signature*** ***Date***

CALLEN LORDE COMMUNITY HEALTH CENTER

Application for Income-Based Discount MRN:_____

Name _____ **Date of Birth:** _____
(Please Print) (MM/DD/YYYY)

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

Please check which financial documents you are providing:

___ Pay Stub
____ Tax Form
____ Bank Statement
____ Letter of Unemployment/Check Stub
____ Letter of Employment
____ 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: _____