CALLEN-LORDE

REGISTRATION FORM

#:_____

PATIENT INFORMATION

Last Name: | First Name: | Middle: | Today's date:

Legal Name (if different): | Date of Birth: | Social Security number:

Billing address: | Apartment #: | Preferred Phone Number:

City: | State: | Zip Code: | Alternate Phone Number:

Pronoun(s): ☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

E-Mail Address for Patient Portal:
*May be used for research studies, if consent given (see page 2).

☐ Do not send marketing communications

Emergency Contact

Emergency contact name: | Emergency contact phone:

The options for some of these questions were provided by our funders; please choose the answer that best fits. Thank You.

Preferred Language:
☐ English ☐ Spanish/Español
☐ American Sign Language (ASL)
☐ Other: _____
Language interpretation services needed?
☐ Yes ☐ No

Gender Identity:
☐ Male/Man
☐ Female/Woman
☐ Trans Male/Trans Man
☐ Trans Female/Trans Woman
☐ Genderqueer/Gender nonbinary
☐ Another Gender: _____
☐ Decline to Answer

Sex Assigned at Birth:
☐ Male ☐ Female

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

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

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

Housing Status:
☐ Stable Housing (not homeless)
☐ Living on Street
☐ Homeless Shelter
☐ Transitional
☐ Pay day-to-day
☐ Doubling Up (not paying rent)
☐ Decline to answer

Veteran?
☐ Yes ☐ No

Migrant Worker?
☐ Yes ☐ No

INSURANCE INFORMATION *Please give card(s) to Front Desk*

☐ I do not have insurance

Insurance carrier: | Policy #: | Group #:

Sex listed on insurance plan: ☐ Male ☐ Female | Name on Insurance Card:

Income

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 ☐ Letter of Employment/Check Stub ☐ Other (please explain):

If you are unable to provide documentation, check all that apply:
☐ I do not have documentation today ☐ I do not get paychecks or pay stubs ☐ I get paid in cash
☐ 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 decline to provide any income information. I understand that this decision may affect my ability to receive sliding scale discounts for services I receive.
Initial Here:

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.

X _____ _____
Patient Signature | Date

CALLEN-LORDE

MR#:_____

PATIENT CONSENT FORM

_____
Please initial

CONSENT FOR TREATMENT:

I 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.

_____
Please initial

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 understand that my insurance may not cover all charges deemed medically necessary by Callen- Lorde and 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.

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.

CONSENT FOR RESEARCH STUDIES:

To better serve our patients, Callen-Lorde regularly conducts research studies on health care, health disparities, and potential health interventions. Please choose one of the options below; the choice you make will NOT affect your ability to get health care services at Callen-Lorde.

Please initial one of these two

☐ ***I GIVE CONSENT*** for Callen-Lorde to contact me (including via phone, text, or e-mail) about research studies. *(Choosing this does not enroll you in any study and you can withdraw your consent to be contacted at any time.)*

☐ ***I DENY CONSENT*** for Callen-Lorde to contact me about research studies.

_____
Please initial

PATIENT RIGHTS AND RESPONSIBILITIES:

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

_____
Please initial

PATIENT HIPAA NOTICE PRIVACY PRACTICES :

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

This signature acknowledges all of the above as initialed. I am aware that Callen-Lorde may or may not contact me based on the above indicated consent choice regarding research studies I may be eligible for.

_____ X_____ ____/____/____

Patient Name (please print) ***Patient Signature*** ***Date***

If this page is being signed by a personal representative, please fill out the information below:

_____ X_____ ____/____/____

Personal Representative Name (please print) ***Signature of Personal Representative*** ***Date***

Authority of Personal Representative to Sign for Patient (**check one**): □Parent □Guardian □Power of Attorney □ Other: _____