

PATIENT INFORMATION

Last Name:	First Name:	Middle:	Legal Name (if different):
Date of Birth:	Social Security Number:	Mobile Phone Number:	Home Phone Number:

Address: _____ **Apartment #:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

Pronoun(s): She/her/hers He/him/his They/them/theirs My name Ze/hir/hirs Email: _____
(Select all that apply) Ey/em/eirs Xe/xem/xyrs Ve/vir/vis Other _____

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

<p>Gender Identity:</p> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Transgender Male/Female-to Male <input type="checkbox"/> Non-binary/genderqueer <input type="checkbox"/> Questioning <input type="checkbox"/> Two Spirit <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> Other _____	<p>Migrant Worker Status:</p> <input type="checkbox"/> Migrant Seasonal <input type="checkbox"/> Not a Migrant Worker <p>Do you have a disability?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say <p>Race: (Select all that apply)</p> <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American Chinese Filipino Guamanian or Chamorro Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Samoan Vietnamese White Choose not to Disclose	<p>Homeless Status:</p> <input type="checkbox"/> Not Homeless <input type="checkbox"/> Currently Not Homeless, was in Last 12 months <input type="checkbox"/> Living in Shelter <input type="checkbox"/> Living with Others <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Veteran At Risk for Homeless <input type="checkbox"/> At Risk for Homeless <input type="checkbox"/> Child At Risk for Homeless <input type="checkbox"/> Homeless Unknown Shelter <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Single Occupancy Hotel <p>Veteran/Military Status:</p> <input type="checkbox"/> No Previous Experience <input type="checkbox"/> Veteran <input type="checkbox"/> Active Duty <input type="checkbox"/> Inactive Duty <input type="checkbox"/> Reservist <p>Ethnicity:</p> <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latinx or Spanish ! >35 Non-Hispanic or Latinx Choose not to disclose
<p>Sexual Orientation:</p> <input type="checkbox"/> Gay <input type="checkbox"/> Pansexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Omnisexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Asexual <input type="checkbox"/> Queer <input type="checkbox"/> Don't Know <input type="checkbox"/> Straight or Heterosexual Choose Not to Disclose Other _____	<p>Sex Assigned at Birth:</p> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Not Recorded on Birth Certificate	
<p>Preferred language: _____ Do you need interpretation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Ethnic Background(s): _____ (e.g. Chinese, Dominican, Persian, Russian)</p>	

EMERGENCY CONTACT

Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone:
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INSURANCE INFORMATION

Please give card(s) to Front Desk I do not have insurance

Insurance Carrier:	Policy Number:	Group Number:
Name on Insurance Card:	Sex Listed on Insurance Plan: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/> Nonbinary <input type="checkbox"/> Unknown	

INCOME

Total Annual Income \$ _____ **Number of Dependents (Include Self)** _____

Please Check Which Financial Documents are you Providing:

 Pay Stub Letter of Unemployment Bank Statement Other _____
 Tax Form Letter of Employment I do not Have Documentation Today _____

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

Patient Signature

Date

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.

Initial one

or

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

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.

Patient Name (please print)

Patient Signature

Date

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

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: _____