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: / /

Cell phone number: ( )

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

Billing address:

Apartment #:

Home phone number: ( )

City: | State: | Zip Code:

Work phone number: ( )

Language interpretation services needed? ☐ No ☐ Yes, language: ________________

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.

Sex Assigned at Birth:
☐ Male ☐ Female

Gender Identity:
☐ Male/Man
☐ Female/Woman
☐ TransMale/Transman
☐ TransFemale/Transwoman
☐ Genderqueer/Gender nonconforming
☐ Something Else
☐ Decline to Answer

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

Veteran?
☐ Yes ☐ No

Hispanic?
☐ Yes ☐ No

Race:
☐ American Indian/ Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White/Caucasian
☐ More than one race
☐ Decline to Answer

Migrant Worker?
☐ Yes ☐ No

Homeless?
☐ Yes ☐ No
If yes, select which best applies:
☐ Street
☐ Homeless Shelter
☐ Transitional
☐ Doubling Up (not paying rent)
☐ Other
☐ Decline to answer

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

Anticipated annual household income for this year:

Total # of people living in household, including yourself:

Please select the statement that best describes your Primary Medical Care status:
☐ I am here for a full physical exam or to establish a relationship with a primary care provider.
☐ I have a primary care provider outside of Callen-Lorde and I plan to continue getting primary care with that provider.
☐ I do not currently have a primary care provider and I am **not** here to establish primary care.

Emergency Contact

Emergency contact name:

Emergency contact phone: ( )

INSURANCE INFORMATION

**Please give your insurance card to the front desk staff. **

If you do not have health insurance, your income will be used to determine your sliding scale discount.

Insurance carrier: | Policy #: | Group #:

Who did you select as your Primary Care Provider with your insurance carrier?

Employer:

Relationship to insured: ☐ Self ☐ Child ☐ Spouse ☐ Partner

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**

MR#:________

CALLEN-LORDE COMMUNITY HEALTH CENTER
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***

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***

3) Patient Rights and Responsibilities:

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

X____ ____/____/____
Patient Signature ***Date***

CALLEN LORDE
COMMUNITY HEALTH CENTER

MRN:___________

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)

____________________________________ ____________________________
Patient Signature Date

OR

____
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: ___________________________

Please note: It is your right to refuse to sign this Acknowledgment

--*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) Staff Member Signature Date

CALLEN LORDE
COMMUNITY HEALTH CENTER

Income Attestation Form **MRN:___________**

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

Please complete the information below to document your gross income:

My total annual income is $________________ **Number of dependents** _________
(Including Self)

I have provided financial documents including (Initial next to all that apply):

____ Employment Pay Stub

____ Payroll Tax Form

____ Bank Statement

____ Unemployment Statement

____ Other (please explain): ____

If you are unable to provide documentation (Initial next to all that apply):

____ I get paid in cash

____ I do not get paychecks or pay stubs

____ I cannot get a letter from my employer

____ I do not earn income

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 a Facilitated Enroller to determine eligibility before receiving a discount for some services.

____ I decline to provide my income information. I understand that this decision may affect
(Initial) my ability to receive possible sliding scale discounts for services I receive at Callen-Lorde.

Signature ____ **Date**__________________