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: ( )
Billing address:		Apartment #:	Home phone number: ( )
City:	State:	Zip Code:	Work phone number: ( )
Language interpretation services needed? ☐ No ☐ Yes, language: ______			

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

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**

Q:________

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;

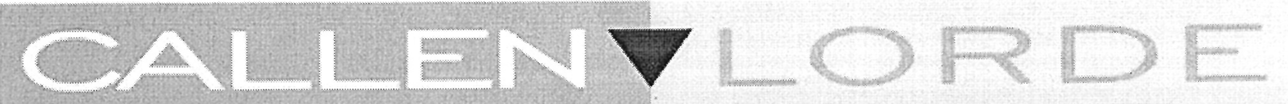
√ I understand that my insurance may not cover all charges deemed medically necessary by Callen-Lorde;

√ 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.

3) Patient Rights and Responsibilities:

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

X________________________________ ____/____/____
Patient Signature ***Date***



Consent for Use and Disclosure of Protected Health Information

Patient Information:

Name: ____________________ SS#: __________________ Phone #: _______________

Address: ____

Consent for Use and Disclosure of Protected Health Information: I, the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above-named patient ("Protected Health Information") shall remain the property of Callen-Lorde Community Health Center (Callen-Lorde). I consent to the use and disclosure of such Protected Health Information as described in Callen-Lorde's *Notice of Privacy Practices for Protected Health Information.* I have been provided with a copy of the *Notice of Privacy Practices for Protected Health Information*, which provides a more complete description of such uses and disclosures, and I have had the right to review the *Notice* prior to signing this *Consent.* I understand that Callen-Lorde reserves the right to change its *Notice* and practices and will promptly make a copy of the revised *Notice* available to me. I understand that I have the right to request restrictions on how Protected Health Information is used or disclosed. I understand that Callen-Lorde is not required to agree to the restrictions requested, but, if it does agree to a requested restriction, that restriction will be binding on it. I understand that I have the right to revoke this *Consent* by notifying Callen-Lorde in writing, except to the extent that Callen-Lorde has already take action in reliance on it.

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient, have read this *Consent for Use and Disclosure of Protected Health Information*, understand its content, and accept its terms. I agree that this *Consent* supercedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding use and disclosure of the Protected Health Information covered by this *Consent*, and I release Callen-Lorde and its health care providers from all liabilities related to their compliance with this *Consent*.

X ____
Signature of Patient or Patient's Parent, Guardian, or Other Authorized Legal Representative

Printed Name of Patient's Representative: ______________________________

Basis of Authority to Act for Patient: ______________________________

Address of Patient's Representative: ______________________________

Telephone Number of Patient's Representative: ______________________________

Date: ___________

Self Attestation Form
Callen-Lorde Community Health Center
Identity/Address/Income/Expenses Documentation Checklist

All Patients must provide or attest for both items 1 & 2

X ____ ____________________

Patient Last Name Patient First Name Q#

1.Proof of Identity

a. Drivers License/ Non-Drivers Photo ID
b. Passport
c. Birth Certificate
d. Baptismal/Other Religious Certificate
e. Official School Records
f.. Adoption Records
g. Official Hospital /Doctor Birth Records
h. Certificate of Naturalization
i. Marriage Records

2. Proof of Address

a. Driver's License / Photo ID
b. Postmarked Mail w/ Name & Address & Date
c. Rent Receipt
d. Property/Mortgage Records

All Patients Requesting a sliding scale discount must provide or attest to section 3, 4, & 5

3. Has the patient already been pre-screened and referred for government funded insurance such as Family Health Plus?

a. Yes, but not eligible
b. Yes, awaiting response from insurance company.
c. No. (If no, please refer patient to Patient Accounts for pre-screening.

4. Proof of Income **X** **Total Income $ ______________________,_____**

Proof of income sources and documents

Source of Income		Documents
a. Wages/Salaries	$________________	Paycheck stubs for last 4 wks__ Employer letter,__ Income Tax Returns__
b. Self Employment	$________________	Income Tax returns, __other records of earnings & expenses__
c. Unemployment	$________________	Award letter,__ Copy of benefit check,__Letter from NYS Dept of Labor__
d. Pension/Annuity	$________________	Statements from Benefit administrator__
e. Social Security	$________________	Award letter__Copy of SSA check,__ Letter from Social Security administrator. __
f. Alimony	$________________	Notarized letter from supporter__Court Letter__Alimony check stub__
g. Veterans Benefits	$________________	Award letter, copy of benefit check
h. Military Pay	$________________	Award letter__, copy of check stub__
i. Rental Income	$________________	Notarized letter from tenant,__ copy of cancelled checks from tenant, receipts__
j. Family Support	$________________	Notarized letter from family member giving support__

**Note: Tax Returns are valid for income verification only through April of following year.*

5. Proof of Dependents **X** **Total No. of dependents including self__________________**

Dependent verification documents

a. Birth certificate
b. Income Tax Returns
c. Other proof

Financial Expenses (only needed if requesting renegotiation of prior debt)

Monthly Rent	$______________________
Utilities	$______________________
Food	$______________________
Prescriptions	$______________________
Other	$______________________
TOTAL	$______________________

X ____ **X** ______________________

Patient Signature Date

Approved for Sliding Scale YES____NO____ If yes, indicate _____%
Approved for Debt Renegotiation YES____NO____ If yes, indicate approved arrangement:________________________

Callen Lorde Staff Signature______________________________Date______________________________