# CALLEN-LORDE

# PATIENT REGISTRATION FORM

Today's Date: _____ MRN: _____

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

Email:

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

**Gender Identity:**
- ☐ Female
- ☐ Male
- ☐ Transgender Female/Male-to-Female
- ☐ Transgender Male/Female-to Male
- ☐ Non-binary/genderqueer
- ☐ Questioning
- ☐ Two Spirit
- ☐ Choose Not to Disclose
- ☐ Other _____

**Sexual Orientation:**
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Straight or Heterosexual
- ☐ Choose Not to Disclose
- ☐ Other _____
- ☐ Pansexual
- ☐ Omnisexual
- ☐ Asexual
- ☐ Don't Know

**Sex Assigned at Birth:**
- ☐ Female ☐ Male ☐ Intersex
- ☐ Not Recorded on Birth Certificate

Preferred language: _____ Do you need interpretation? ☐ Yes ☐ No

**Migrant Worker Status:**
- ☐ Migrant ☐ Seasonal
- ☐ Not a Migrant Worker

**Do you have a disability?**
- ☐ Yes ☐ No ☐ Prefer not to say

**Race: (Select all that apply)**
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Black/African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Choose not to Disclose

Ethnic Background(s): _____ (e.g. Chinese, Dominican, Persian, Russian)

**Homeless Status:**
- ☐ Not Homeless
- ☐ Currently Not Homeless, was in Last 12 months
- ☐ Living in Shelter
- ☐ Living with Others
- ☐ Street, Camp, Bridge
- ☐ Transitional Housing
- ☐ Veteran At Risk for Homeless
- ☐ At Risk for Homeless
- ☐ Child At Risk for Homeless
- ☐ Homeless Unknown Shelter
- ☐ Permanent Supportive Housing
- ☐ Single Occupancy Hotel

**Veteran/Military Status:**
- ☐ No Previous Experience
- ☐ Veteran ☐ Active Duty
- ☐ Inactive Duty ☐ Reservist

**Ethnicity:**
- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Another Hispanic, Latinx or Spanish - JA?AF
- ☐ Non-Hispanic or Latinx
- ☐ Choose not to disclose

## EMERGENCY CONTACT

| Emergency Contact Name: | Emergency Contact Relationship: | Emergency Contact Phone: |
|---|---|---|
| | | |

## 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: ☐ Male ☐ Female ☐ X ☐ Nonbinary ☐ Unknown

## INCOME

Total Annual Income $ _____ Number of Dependants (Include Self) _____

Please Check Which Financial Documents are you Providing:
- ☐ Pay Stub
- ☐ Tax Form
- ☐ Letter of Unemployment
- ☐ Letter of Employment
- ☐ Bank Statement
- ☐ I do not Have Documentation Today
- ☐ Other _____

*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

# CALLEN-LORDE

# PATIENT CONSENT FORM

Today's Date: _____ MRN: _____

_____
*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 PatientFinancial 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 |
|---|---|---|

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*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: _____