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: _____

MRN#:_____ Date:_____

CALLEN-LORDE

MEDICAL HISTORY FORM

☐ Reviewed by Provider

Provider:_____

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth: / /

Primary Care

Do you get your primary (basic) medical care at Callen-Lorde?

☐ Yes

☑ No **Please let us know where you go**

☒ I don't have a primary medical provider **Please see the Front Desk**

Name of clinic/hospital/practice: _____

Provider Name: _____ Phone Number: _____

General History

Housing:

What is your housing status?

☐ Stable housing (not homeless) ☐ Transitional

☐ Living on street ☐ Pay day-to-day

☐ Homeless Shelter ☐ Doubling Up (not paying rent) ☐ Decline to answer

Alcohol:

Do you drink alcohol? ☐ Yes ☐ No ☐ I used to. Year quit:_____

If Yes: How many times in the past year have you had 4 or more drinks in a day? _____

Sexual Practices:

Have you been sexually active in the last 3 months? ☐ Yes *See Below* ☐ No

What kind of sex do you have?			Who are your sexual partners for each activity?		
Anal-receptive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Anal-insertive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Vaginal-receptive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Vaginal-insertive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Oral-receptive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Oral-insertive	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both
Oral-anal	☐ Yes	☐ No	☐ Male assigned at birth	☐ Female assigned at birth	☐ Both

Confidential Information

If not listed below please speak to your provider

Drug Use:

☐ Current (in the last week)

☐ In the past

☐ Never

If current or in the past, what drug(s) do you use or used to use?

☐ Cocaine.....	☐ I quit
☐ Crystal Meth/Tina.....	☐ I quit
☐ Ecstasy (Molly).....	☐ I quit
☐ Heroin.....	☐ I quit
☐ Marijuana.....	☐ I quit
☐ Poppers.....	☐ I quit

CALLEN-LORDE

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Callen-Lorde Community Health Center to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Callen-Lorde Community Health Center to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Callen-Lorde Community Health Center to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

CALLEN-LORDE

Healthix

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Callen-Lorde Community Health Center at: 212-271-7200; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.