Label Here

- All information is confidential -

Name (preferred):____ Birth date:_____/_____/______

You will be called by this name at the clinic and when our staff contacts you by telephone.

What pronouns do you use? another pronoun ________________________

Legal name/name listed on your insurance card:____

This name will be used for prescriptions, lab orders and billing purposes. Bills will be sent to your insurance company or mailing address by this name.

Sex marker on your insurance: female no insurance

female ale non-

Social Security #___ ___ ___-___ ___-___ ___ ___ ___ Your Phone #_______________________________

Can we identify ourselves as Family Tree Clinic when we call this number?

Can we leave a detailed voicemail with protected health information at this number? yes

Email address____

Mailing address:____

Street address Apt # City State Zip

Emergency contact name:_________________________ Emergency contact phone #:____________________

PATIENT DEMOGRAPHIC INFORMATION check all that apply to you

Race & Ethnicity

Native American or Alaska Native

-racial

Hispanic/Latino/Latina/Latinx

-Hispanic/Latino/Latina/Latinx

other race or ethnicity _____________

Country of origin: ________________________

Gender identity: (please check all that apply to you)

(current gender is different from what was assigned at birth)

gender *(current gender identity matches what was assigned at birth)*

woman non-binary -conforming

agender another identity ___________

Sexual Orientation: asexual pansexual

declined to answer another orientation ____

How did you hear about Family Tree Clinic?

Radio Event:__________ Organization:____________

Sex Ed class _____ Other:____________________

Rooming Policy: To provide high quality, comprehensive and confidential care, it is our policy to see each patient alone for a portion of their visit. Patients are roomed by themselves and meet alone with the clinician or patient educator at the beginning of the visit. Once this process is complete, you can request to have your companion escorted to the exam room to join you.

OVER

Label Here

INCOME AND PAYMENT INFORMATION

What is your gross MONTHLY income (before taxes)? $________________ per month

How many people (including you) are supported by this income? 1 2 3 4 5 6 other______

Which payment method will you be using?

□ **Sliding fee scale** – I will pay based on my income with cash, check or credit card at the time of service.

□ **Insurance or State Program** (including MFPP) – I hereby authorize Family Tree Inc. to release to my insurance or program any information, including diagnosis and records of treatment concerning my medical care. I request payment of services to be made to Family Tree. I understand that if I am covered by my parent's policy and want Family Tree to bill the insurance for my visit, my parents may receive a copy of the charges from their insurance company. *Note: Insurance companies are billed for the full cost of the visit. If your insurance company doesn't cover any portion of your visit, you will be responsible for the unpaid balance.*

Patient Authorization and Consent

Patient's Right to Privacy: By signing below, I acknowledge that I have reviewed a copy of the Privacy Notice. Public copies of the Privacy Notice and Client's Rights and Responsibilities brochure are posted in the reception area.

Consent for Treatment: By signing below, I consent to having my healthcare provider examine and treat me. I understand that this could include education, lab tests, and/or diagnostic procedures. I understand that my provider will explain the purpose of procedures and treatments and that I have the right to refuse the recommended treatment.

Research: I understand that you conduct or participate in medical research to better understand health, disease, and how care is provided. By signing below, I agree that you may share my anonymous health information for research studies, unless I initial here: ______

Income Verification: By signing below, I certify that all information regarding my income is complete and correct.

Authorization for Payment: By signing below, I give permission for my insurance carrier to pay Family Tree Clinic directly. I understand that I am responsible for payment of all co-insurance and deductibles, as well as any treatment, care and services not covered by my insurance.

____ ____________________

Signature of patient/legal representative Date

If legal representative, relationship to patient ____________________________________