Label Here

FAMILY TREE CLINIC
1919 Nicollet Avenue
Minneapolis, MN 55403
Phone: 612-473-0800

-All information is confidential-

Full Name _____ **Date of Birth** _____
You will be called this name at the clinic and when our staff contacts you by telephone.

Legal Name (name listed on your insurance card): _____
This name will be used for prescriptions, lab orders and billing. Bills will be sent to your insurance company or mailing address by this name.

What pronouns do you use? □ she/her □ he/him □ they/them □ another pronoun_____
Sex marker on your insurance: □ female □ male □ no insurance
Sex marker on your driver's license, ID or passport: □ female □ male □ non-binary or "X"

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Patient's phone number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Can we identify ourselves as Family Tree Clinic when we call this number? □ yes □ no
Can we leave a detailed voicemail with protected health information at this number? □ yes □ no

Patient's Mailing Address: _____
street address *apt #* *city* *state* *zip code*

Email Address: _____

Does this email address belong to the patient? □ yes □ no
If no, please provide the name and relationship to the patient: _____

Emergency Contact Name: _____ Phone Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Accommodations: Do you require any accommodations for your appointments? □ language □ ADA □ none

Patient Demographic Information - check all that apply -

Race
□ Asian □ Black/African American
□ Native American or Alaska Native
□ white □ multi-racial
Ethnicity
□ Hispanic/Latino/Latina/Latinx
□ Non- Hispanic/Latino/Latina/Latinx
□ another race/ethnicity _____

Country of Origin: □ U.S. □ other _____

Gender Identity: (please check all that apply)
□ transgender *(current gender is different from what was assigned at birth)*
□ cisgender *(current gender identity matches what was assigned at birth)*

□ woman □ man □ non-binary □ gender non-conforming
□ gender queer □ agender □ another identity_____

Sexual Orientation: □ straight/heterosexual □ gay □ lesbian □ bisexual □ queer □ asexual □ pansexual
□ decline to answer □ another orientation_____

OVER →

Income and Payment Information

How many people (including you) are supported by a shared income? 1 2 3 4 5 6 other _____

What is the gross MONTHLY income of your financial household? $_____ per month

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.*

How did you hear about Family Tree Clinic?
□ Radio □ Other Clinic □ Internet □ Family/Friends/Partner □ Event: _____ □ Organization: _____
□ Bus Ad □ High School □ Hotline □ Sex Ed class □ College: _____ □ Other: _____

Patient Authorization and Consent

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

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 or Legal Representative **Date**

_____ _____
If Legal Representative: Name **Relationship to Patient**