Island Health Care
A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order.

**Medical Record #**
*(For office use only)*

*V. 4_9_2020*

# Patient Registration

| | | | |
|---|---|---|---|
| **Legal Name** (Printed) Last | First | Middle Initial | **Name used** (if different): |
| **Legal Sex (please check one)*** ( ) Female ( ) Male<br>**While Island Heath Care (IHC) recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and gender reference are different from these, please let us know in the space to the right.* | | | **Preferred** (if different): |
| **Date of Birth** *Month Day Year*<br>/ / | | **Social Security #** | |

***Your answers to the following questions will help us reach you quickly and discreetly with important information.***

| | | | |
|---|---|---|---|
| **Home Phone**<br>( )<br>OK to leave a voice message | **Cell Phone**<br>( )<br>__ OK to text or voice message | **Work Phone**<br>( )<br>__OK to leave a voice message | **Best number to reach you:**<br>___Home____Cell___Work |
| **Address** (P.O. Box if you have one) | City | State | ZIP |
| **Email address:** | | | |
| **Occupation** | Employer/School Name | Are you covered under school or employer's insurance?<br>☐ Yes ☐ No | |
| **Emergency Contact's Name** | Phone Number | Relationship to you | |
| *If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.*<br>**Parent/Guardian Name** | Phone Number | Relationship to you | |

***This information is for demographic purposes only, without personal identifiers and does not affect your care.***

| | | | |
|---|---|---|---|
| **1) What is your annual income?**<br>$_____<br>❑ No income<br>**1a) How many people (including you) does your income support**<br># _____ | **3) Insurance**<br>**3a)** Primary Insurer:<br>_____<br>Subscriber name:<br>_____<br>Member ID:<br>_____<br>**3b)** Secondary Insurer:<br>_____<br>Subscriber name:<br>_____<br>Member ID:<br>_____ | **4) Racial Group(s) (check all that apply)**<br>❑ African-American / Black<br>❑ Asian<br>❑ Brazilian/African-American Black<br>❑ Brazilian / White<br>❑ Caucasian / White<br>❑ Native American / Alaskan Native / Inuit<br>❑ Pacific Islander<br>❑ Other _____ | **5) Ethnicity**<br>❑ Hispanic/Latino/Latina<br>❑ Not Hispanic/Latino/Latina<br>❑ Brazilian/Not Hispanic<br>**6) Housing Status**<br>❑ Rent<br>❑ Public housing?<br>❑ Is rent based on income?<br>❑ Own home<br>❑ Living in transitional housing<br>❑ Homeless or homeless shelter |
| **2) Veteran Status**<br>❑ Veteran<br>❑ Not a Veteran<br>❑ Other | | | |
| **7) What is your gender?**<br>❑ Female<br>❑ Male<br>❑ Genderqueer or not exclusively male or female<br>**8) What was your sex assigned at birth?**<br>❑ Female<br>❑ Male | **9) Do you think of yourself as:**<br>❑ Lesbian, gay, or homosexual<br>❑ Straight or heterosexual<br>❑ Bisexual<br>❑ Something else<br>❑ Don't know | **10) Do you identify as transgender or transsexual?**<br>❑ No<br>❑ Yes – Male to Female<br>❑ Yes – Female to Male<br>❑ Yes – Non--binary<br>❑ Don't know | **11) Referral Source (how did you hear about us?)**<br>❑ Self<br>❑ Friend or Family Member<br>❑ Health Provider<br>❑ Emergency Room<br>❑ Ad/Internet/Media<br>❑ Outreach Worker<br>❑ School<br>❑ Other _____ |
| **12) Marital Status**<br>❑ Married<br>❑ Partnered<br>❑ Single<br>❑ Divorced<br>❑ Other_____ | **13) Preferred Language (choose one)**<br>❑ English<br>❑ Español<br>❑ Português<br>❑ Other _____ | **14) Are you a seasonal farm worker?**<br>❑ Yes<br>❑ No | **Please turn over**<br>  |

# Island Health Care – Consent for Treatment

Patient Name_____Date of Birth:_____Time:_____(A.M./P.M.)
(Printed) MM/DD/YYYY

I hereby give my consent and authorize Island Health Care to treat any medical condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously.

I understand that Island Health Care operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

## Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Island Health Care may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I may request a copy of IHC Patient Rights and Grievance Resolution process.

I certify that the above information is true and correct.

Patient Signature:_____ Date: _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;;
- Proposed treatments, procedures, or research activities;;
- Potential benefits and drawbacks of proposed treatments or procedures;;
- Problems related to recuperation;;
- Alternative treatment(s) or procedure(s);;
- The physician or other practitioner primarily responsible for the patient's care;;
- Others authorizing or performing procedures or treatments;; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.