community health centers OF BURLINGTON

PATIENT REGISTRATION FORM

Verified By:

DATE REC/ENTERED: ____/____/____

STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ **MEDICAL** ☐ **DENTAL**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ GoodHEALTH ☐ Winooski Family

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MI | NICKNAME/CHOSEN NAME

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____

Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION

Family/Household Size: _____

Household Income: $ _____

☐ Weekly ☐ Annually
☐ Biweekly ☐ Refused
☐ Monthly

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

PRONOUNS (Optional):

_____

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO

If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**

☐ **I currently DO NOT have DENTAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary DENTAL insurance (see below)**

Dental Insurance Name: _____

Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**

☐ **I currently DO NOT have MEDICAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary MEDICAL insurance (see below)**

Medical Insurance Name: _____

Policy/ID Number: _____

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Consent for Treatment and Consent to Release Health Information

for Treatment, Payment and Health Care Operations

I. Consent for treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release of health information, including health/treatment records for treatment, payment and health care operations:

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHCB for the following purposes:

A. Use of health information by or for CHCB for treatment, payment, and health care operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including financial or quality assurance audits and/ or training.
- Payment for services provided by CHCB. CHCB is authorized to obtain payment for health care services and can provide health information to insurance companies, workers compensation insurers or other agencies that pay for health services, as identified in my CHCB registration form or other updated insurance information on file with CHCB.

B. Disclosure of health information to persons or organizations outside of CHCB for treatment purposes:

CHCB is authorized to provide all necessary health information as determined by CHCB, including information about treatment for substance use disorders to any of the following health providers if I am referred there for medical treatment:

- **Hospitals:** University of Vermont Medical Center (UVMMC), Copley Hospital, Porter Hospital, Northwestern Medical Center, Central Vermont Medical Center (CVCA), Dartmouth Hitchcock Medical Center (DHMC)
- **Allergy:** Timberlane Allergy & Asthma Associates
- **Audiology:** Adirondack Audiology Associates
- **Cardiology:** CVCA, Central VT Cardiology, NWMC Cardio, DHMC Cardiology
- **Dermatology:** Dorset St. Dermatology, Four Seasons Dermatology
- **Gastroenterology:** VT Gastroenterology, Northwestern Medical Center
- **Home Health:** Bayada Home Health, UVMMC Home Health & Hospice
- **Neurology:** DHMC Neurology, Neurological Associates of Burlington
- **OB/GYN:** Lake Champlain Gynecology, Maitri, VT Gynecology
- **Ortho:** NWMC Ortho, Mansfield Ortho
- **Oximetry:** Lincare
- **Pain Clinic:** VT Interventional Spine Center, VT Pain Management, UVMMC Pain Management
- **Radiology:** CVMC Radiology, NWMC, Porter, Copley and VT Open MRI
- **Sleep Study:** VT Medical Sleep Disorder, UVMMC Sleep Program
- **Urology:** DHMC Urology, Green Mountain Urology
- **Veterans** Veterans Administration Programs and Facilities
- **Physical Therapy:(PT)** PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Elite Health &

Wellness, Essex PT, Every Woman, Evolution Therapy & Yoga, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Injury & Health Management Solutions, Inspire PT, Island PT, Living Well Center for Integrated Health, Long Trail PT, On Track PT, Peak PT, Pelvic Health, Phoenix PT, Pinnacle PT, Rehab Gym, Transitions PT, Timberlane PT, Vasta PT, and Vermont PT.

- CHCB is authorized to provide all health information to other health providers or agencies not listed who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);

III. Termination and restrictions of this consent:

I understand that I have the right to revoke this consent at any time, but revoking this consent will not affect any actions which were taken by CHCB in reliance on this consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition:_____ if none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHCB may or may not agree to requested the restrictions. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed consent.

IV. Assignment of Benefits

I hereby assign to CHCB any and all payments to which I am entitled under Medicaid, Medicare, or any health insurance policy for health care, behavioral health, psychiatry or dental health services rendered to me by CHCB. I further authorize CHCB to bill and receive payment directly from Medicaid /Medicare or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB

to give Medicaid / Medicare or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct**.**

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHCB will use my protected health information in accordance with privacy law.

I understand that the Community Health Centers of Burlington, Inc. may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements. I understand that e-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

REQUIRED

Name of Patient:_____ Date of Birth_____

Patient Signature:_____ Date:_____

Parent/Guardian:_____

Parent/Guardian Signature:_____ Date:_____

Vermont Health Information Exchange (VHIE)
Opt-Out Consent Form

If you DO NOT want health care professionals involved in your care to see your general health information in the VHIE, please fill out this form.

Do you have access to the web or a smartphone? You can Opt-Out using a WebForm at www.vthie.net

Full Name (First Middle Last, Suffix)* _____ Date of Birth (mm/dd/yyyy)* _____

Physical Address (Street, Apt/Unit, City, State, Zip)* _____

Primary Phone Number (include area code)* _____ Alternate Phone Number (include area code) _____

Email Address (only for processing this form) _____ Name of Health Care Organization(s) you visit _____

By signing below **I choose to Opt Out** - Please **hide** my records in the VHIE to health care organizations involved in my care.

I understand that falsifying my identity or signing on behalf of an individual in which I do not have authority is against the law and a punishable offense. For more information on signature requirements please contact VITL or discuss with your health care organization.

Signature of Patient (if patient is 12 years or older) _____ Date _____

Signature of Parent or Authorized Representative _____ Date _____

- If patient is younger than 12 years old, signature of Parent or Authorized Representative is required.
- If patient is 12 or older, but not yet 18, signature of Parent or Authorized Representative is optional.

Name of Parent or Authorized Representative _____ Relationship to Patient _____

Once complete please mail, fax, or deliver in person to VITL
Vermont Information Technology Leaders – VITL
Attn: VHIE Support
1 Mill Street, Suite #249
Burlington, VT 05401
Fax# 802-461-4208

Questions? Call VITL toll free – Consent Hotline 1-888-980-1243 or www.vthie.net