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

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

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

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

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

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: _____

Swahili

FOMU YA KUWASAJILI WAGONJWA

Imethibitishwa Na:

TAREHE ILIYOPOKEWA / KUWEKWA: ___/___/___

HERUFI ZA KWANZA ZA MAJINA YA WAFANYAKAZI: _____

AINA YA MIADI/YA KUTUMIWA NA WAFANYAKAZI PEKEE ☐ MATIBABU ☐ MENO

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

MAELEZO YA MGONJWA *TAFADHALI KAMILISHA (Jaza) fomu yote kwa Kalamu yenye rangi Nyeusi au Bluu Pekee*

JINA LA MWISHO | JINA LA KWANZA | MI | JINA LA UTANI/JINA ULILOCHAGUA

ANWANI YA MTAA | MJI | JIMBO | MSIMBO WA ENEO

NAMBARI YA RUZUKU YA SERIKALI | TAREHE YA KUZALIWA | SIMU YA NYUMBANI | SIMU YA MCHANA | SIMU YA MKONONI

ANWANI YA BARUA PEPE

MBINU INAYOPENDELEWA YA MAWASILIANO
☐ SIMU ☐ BARUA PEPE ☐ UJUMBE WA MATINI

HALI YA NDOA
☐ Mseja ☐ Mmetengana ☐ Mjane ☐ Umeolewa/Umeoa ☐ Umepewa talaka ☐ Ndoa ya Jinsia Moja

UMBARI
☐ Mwafrika-Mwamerika ☐ Mwamerika Asili ☐ Mwasia-Mwamerika ☐ Mpasifiki wa Kisiwa ☐ Mzungu ☐ Chotara

Lugha Msingi kama Sio Kiingereza: _____

Unahitaji Huduma za Mkalimani? ☐ NDIYO ☐ HAPANA

Asili ya Jamii/Kabia: ☐ Mhispania ☐ Asiye Mhispania

Daktari wa Huduma ya Msingi

MFANYAKAZI WA KILIMO
☐ Mhamiaji ☐ Wa muda

Je, wewe ni Mkongwe wa Marekani?
☐ Ndiyo ☐ Hapana

MAELEZO YA KIFEDHA YA FAMILIA
Ukubwa wa Familia/Kaya: _____
Mapato ya Kaya: $ _____
☐ Kila wiki ☐ Kila mwaka ☐ Baada ya wiki mbili ☐ Amekataa ☐ Kila mwezi

Kama Kituo cha Afya ambacho hupokea Fedha za serikali, tunahitajika kukusanya maelezo haya. Majibu yote ni ya siri.

JINSIA HALALI
☐ MWANAUME ☐ MWANAMKE

JINSIA YA SASA
☐ MWANAUME ☐ MWANAMKE

VIWAKILISHI (Hiari):

UTAMBULISHO WA JINSIA
☐ MWANAUME
☐ MWANAMKE
☐ MWANAUME ALIYEBADILISHA JINSIA (Mwanamke-hadi-Mwanaume/FTM)
☐ MWANAMKE ALIYEBADILISHA JINSIA (Mwanaume-hadi-Mwanamke/MTF)
☐ MTU ASIYEJITAMBULISHA NA JINSIA YOYOTE
☐ NYINGINEZO
☐ NINACHAGUA KUTOFICHUA

MAPENDELEO YA KIMAPENZI
☐ MPENDA JINSIA TOFAUTI au WANAOFANYA MAPENZI YA KAWAIDA
☐ MSAGAJI, BASHA au MSENGE
☐ MPENDA JINSIA ZOTE MBILI
☐ KITU KINGINE
☐ SIJUI
☐ NINACHAGUA KUTOFICHUA

HALI YA MAKAZI Una Makazi? ☐ NDIYO ☐ HAPANA

Ikiwa huna makazi, unaishi: ☐ Doubling Up (unaishi na wengine) ☐ kwa Makazi ☐ Mtaani ☐ Makazi ya mpito ☐ Haijulikani

DUKA LA DAWA UNALOPENDELEA

JINA LA DUKA LA DAWA | ENEO LA DUKA LA DAWA

MAWASILIANO YA DHARURA

JINA | UHUSIANO | NAMBARI YA SIMU

MAELEZO YA MHUSIKA ANAYEWAJIBIKA (Mgonjwa yeyote chini ya umri wa miaka 18 lazima awa na mhusika anayewajibika)

☐ **Mgonjwa**(umri wa miaka 18 au zaidi) ☐ **Mzazi Mlezi** ☐ **Mlezi** (thibitisho la hali ya kisheria inahitajika kwa matibabu)

JINA LA MWISHO | JINA LA KWANZA | MI

ANWANI YA MTAA | MJI | JIMBO | MSIMBO WA ENEO

TAREHE YA KUZALIWA | SIMU YA NYUMBANI

MAELEZO YA BIMA YA MENO

☐ **Kwa sasa nina bima ya MENO (angalia hapa chini)**

☐ **Kwa sasa SINA bima ya MENO**

☐ **Ningependa kuomba ADA INAYOPUNGUA (KIWANGO CHA ADA INAYOPUNGUA)**

Jina la Bima ya Meno: _____

Nambari ya Sera/Kitambulisho: _____

☐ **Kwa sasa nina bima ya pili ya MENO (angalia hapa chini)**

Jina la Bima ya Meno: _____

Nambari ya Sera/Kitambulisho: _____

MAELEZO YA BIMA YA MATIBABU

☐ **Kwa sasa nina bima ya MATIBABU (angalia hapa chini)**

☐ **Kwa sasa SINA bima ya MATIBABU**

☐ **Ningependa kuomba ADA INAYOPUNGUA (KIWANGO CHA ADA INAYOPUNGUA)**

Jina la Bima ya Dawa: _____

Nambari ya Sera/Kitambulisho: _____

☐ **Kwa sasa nina bima ya pili ya MATIBABU (angalia hapa chini)**

Jina la Bima ya Dawa: _____

Nambari ya Sera/Kitambulisho: _____

community health centers OF BURLINGTON

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 &

Ridhaa ya Matibabu na Ridhaa ya Kutoa Maelezo ya Afya

kwa Shughuli za Matibabu, Malipo na Huduma ya afya

I. Ridhaa ya Matibabu

Ninatoa ridhaa yangu kwa matibabu yangu mwenyewe, au mgonjwa aliyetajwa (ambaye mimi ni mzazi au mlezi wake halali ambaye ana haki ya kutoa ridhaa ya matibabu ya mgonjwa aliyetajwa) kwa Vituo vya Afya vya Jamii vya Burlington, Inc. (CHCB). Matibabu yanaweza kujumuisha uchunguzi wa afya, uaguzi, matibabu, matibabu ya meno; huduma za jamii; na/au afya ya akili na uchunguzi unaohusiana na dawa za kulevya na pombe, tathmini, uaguzi na matibabu.

II. Ridhaa ya Kutoa Maelezo ya Afya, pamoja na Rekodi za Afya/Matibabu kwa ajili ya Matibabu, Malipo na Shughuli za Huduma ya Afya

Ninatoa ridhaa kwa matumizi ya ndani ya CHCB na ufichuzi kwa watu au mashirika nje ya CHCB ya maelezo yangu (au ya mgonjwa aliyetajwa ambaye mimi ni mzazi au mlezi wake halali) ya matibabu, meno, dawa za kulevya na pombe, afya ya akili na matibabu yangu mengine na rekodi za afya (rekodi na maelezo kama hayo ya afya yanarejelewa katika Ridhaa hii kama "Maelezo yangu ya Afya") na CHCB kwa malengo yafuatayo:

A. Matumizi ya Maelezo ya Afya na CHCB kwa Matibabu na kwa Shughuli za Huduma ya Afya:

- Kutoa matibabu kwa wafanyakazi wa CHCB:
- Kutekeleza shughuli za huduma ya afya za CHCB ikiwa ni pamoja na, kwa mfano, ukaguzi na mafunzo ya kifedha au kuhakikisha ubora.

B. Ufichuzi wa Maelezo ya Afya kwa Watu Nje ya CHCB kwa Malengo ya Matibabu na Malipo

- Kutoa Maelezo yote muhimu ya Afya kama ilivyobainishwa na CHCB, ikiwa ni pamoja na maelezo kuhusu matibabu ya matumizi mabaya dawa na pombe, kwa yeyote kati ya watoa huduma wafuatao wa afya ikiwa nitaelekezwa hapo kwa matibabu: University of Vermont Medical Center, Allergy & Asthma Associates, Champlain Valley Foot & Ankle, Associates in Orthopedic Surgery, Appletree Bay Physical Therapy, Four Seasons Dermatology, Evolution Physical Therapy & Yoga, Hand Surgery Associates, Green Mountain Physical Therapy, or the Rehab Gym.
- Kutoa Maelezo ya Afya kwa watoa huduma wengine wa afya mashirika ambayo hayajaorodeshwa hapo juu ambaye huenda wanahusika katika huduma yangu (isipokuwa kwa maelezo yanayohusiana na matibabu ya matumizi mabaya ya dawa au pombe ambapo ridhaa tofauti itahitajika);
- Kupata malipo ya bili za huduma ya afya, pamoja na kutuma Maelezo kama hayo ya Afya kama yanavyohitajika ili kupata malipo kwa huduma za CHCB kwa kampuni ya bima, kampuni ya kuwafidia wafanyakazi au shirika linalolipia huduma zangu za afya, kama ilivyotambuliwa katika fomu yangu ya Usajili ya CHCB au maelezo mengine mapya ya bima kwenye faili ya CHCB.

III. Masuala Mengine

Ninaelewa kwamba nina haki ya kubatilisha Ridhaa hii wakati wowote, lakini kubatilisha Ridhaa hii hakutaathiri hatua zozote ambazo zilichukuliwa na CHCB kwa kutegemea Ridhaa hii kabla ya kuibatilisha. Ikiwa haikubatilishwa awali, ridhaa hiki itaisha baada ya tarehe, tukio, au hali inayofuata: _____. Ikiwa hakuna iliyoashiriwa, ridhaa hii itaisha miaka mitatu baada ya tarehe ya mwisho ya mimi kupata huduma.

Ninaelewa kwamba ninaweza kuomba vikwazo kwa matumizi au ufichuzi wa Maelezo yangu ya Afya kwa malengo yaliyoelezewa katika Ridhaa hii na kwamba huenda CHCB isikubali vikwazo vilivyoombwa. Ninaelewa pia kwamba isipokuwa kwa vikwazo vya matumizi au ufichuzi wa Maelezo ya Afya ambavyo CHCB imekubali, CHCB haitaweza kunipa huduma (au mtu aliyetajwa) bila Ridhaa iliyotiwa saini.

Ninaelewa na kukubali kwamba ninawajibika kifedha kwa masalio yoyote yasiolipwa yaliyotokana na huduma yangu katika CHCB.

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:_____

Idhini ya Mgonjwa

617 Riverside Avenue Burlington, VT 05401 Simu: (802) 864-6309 Faksi: (802) 860-4324 www.chcb.org

Ninaelewa kwamba, kwa ufahamu wangu wote, maelezo ya demografia niliyoyatoa ni ya kweli na sahihi.

Nimesoma Ridhaa ya Matibabu na Ridhaa ya Kutoa Maelezo ya Afya na ninaelewa na kutoa ridhaa ya maudhui yake.

Ninakubali kwamba nimepewa nakala ya hati ya Matarajio ya Malipo ya CHCB na ninaelewa na kukubali kufuata matarajio haya.

Kukabidhi Faida
Ninaikabidhi CHCB malipo yoyote na yote ambayo ninastahiki chini ya Medicaid au sera yoyote ile ya bima ya afya kwa huduma ya afya, afya ya kitabia, au huduma za afya ya meno nilizopewa na CHCB ilimradi gharama hizo za huduma kwa CHCB zisidishe gharama za kawaida za CHCB. Ninaidhinisha CHCB kutoa bili na kupokea malipo moja kwa moja kutoka Medicaid au mtoa huduma wa bima yangu kwa huduma hizo ambazo CHCB ilitoa ambazo ninaweza kustahiki kupata bima. Ninaidhinisha pia CHCB kutoa maelezo yoyote yanayohitajika ya Medicaid au ya bima yangu ya afya kwa malengo ya bili kwa huduma zilizotolewa kwa muda wa vipindi hivyo nikipokea au ninapokuwa nikipokea huduma msingi ya afya, au huduma za afya ya kitabia, au afya ya meno.

Wagonjwa katika Vituo vya Afya vya Jamii vya Burlington wanatoa ridhaa ya kufichuliwa kwa maelezo kwa malengo ya matibabu, malipo, na shughuli za huduma ya afya. Wagonjwa wanaweza kutoa ridhaa ya kupokea au kufichuliwa kwa maelezo ya huduma ya afya kwa malengo mengine pia.

Wagonjwa wanaoomba maelezo kuhusiana na ushauri/matibabu ya dawa za kulevya na pombe wanahitaji kukamilisha idhini tofauti. Hakuna maelezo ya dawa za kulevya na pombe yatakayotolewa bila kibali hiki.

Ninakiri kwamba nimepewa nakala ya Ilani ya Kanuni za Faragha na ninaelewa jinsi CHCB inaweza au kutoweza kutumia maelezo yangu yaliyolindwa ya afya kulingana na sheria ya faragha.

Ninaelewa kwamba Vituo vya Afya vya Jamii vya Burlington, Inc. vinaweza kutumia anwani yoyote ya barua pepe au nambari ya simu ya mkononi iliyotolewa kuwasiliana na mimi kwa makumbusho ya miadi au matangazo mengine. Anwani za barua pepe na nambari za simu ya mkononi hazitauzwa kwa wahusika wengine au kutumiwa kwa malengo ya matangazo.

INAHITAJIKA

Jina la Mgonjwa:_____ Tarehe ya Kuzaliwa_____

Saini ya Mteja:_____ Tarehe:_____

Mzazi/Mlezi: _____

Saini ya Mzazi/Mlezi:_____ Tarehe:_____

Ilirekebishwa mnamo Julai 2016