# FOOMKA DUWAAN GELINTA BUKAANKA

NOOCA BALANTA/KALIYA SHAQAALAHA AYAA ISTICMAALAYA ☐ CAAFIMAADKA ☐ DARYEELKA ILKAHA

**Waxaa Xaqiijiyay:**
TAARIIKHDA DUWAANKA/ GELINTA:____/____/____

XARFAHA URUURISKA MAGACA SHAQAALAHA:____

Community Health Centers

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ Good Health ☐ Winooski ☐ Essex

**MACLUUMAADKA BUKAANKA** *FADLAN KU BUUXI (Buuni) foomka oo dhar Walin Madaw ama uluug ah oo Kaliya*

| MAGACA SADEXAAD | MAGACA KOWAAD | MAGACA DHEXE | NAANAYS |
|---|---|---|---|
| | | | |

| CINWAANKA JIDKA | MAGAALADA | GOBOLKA | ZIP-KA |
|---|---|---|---|
| | | | |

| LAMBARKA SOOSHAAL SEKUURITIGA | TAARIIKHDA DHALASHADA | TALEEFANKA GURIGA | TALEEFANKA MAALINKII | TALEEFANKA GACANTA |
|---|---|---|---|---|
| | | | | |

CINWAANKA IIMEELKA

QAABKA XIDHIIDHKA LA DOORBIDAYO
☐ TALEEFANKA ☐ IIMEEL ☐ FARIIN QORAAL AH

XAALADA GUURKA
☐ Kali ☐ Kala Maqan
☐ Xaas Leh ☐ Carmal
☐ Is Furay ☐ Iska Wada Nool

ISIR
☐ Maraykan Madaw ☐ Dhalad Maraykan
☐ Aasiyaan Maraykan ah ☐ Jasiirada Baasifiga
☐ Cadaan ☐ Qoomiyado badan

Luuqada Kowaad Hadii Ayna Ingiriisi Ahayn: ____

Miyaad U Baahan Tahay Adeegyada Turjubaada? ☐ HAA ☐ MAYA

Qoomiyad/Isirka Uu Kasoo Jeedo: ☐ Hisbaanid ☐ Aan Ahayn Hisbaanig

Dhakhtarka Daryeelka Kowaad

SHAQAALAHA BEERAHA
☐ Soo Galayti ☐ Xiliyeed

Ciidan Maraykan oo shaqada ka fadhiistay ayaad tahay?
☐ Haa ☐ Maya

MACLUUMAADKA DHAQAALAHA QOYSKA
**Xarunta Caafimaad oo qaadata ahaan deeqda Federalka, waxaa nagu waajib ah in aanu uruurino macluumaadkan. Dhamaan jawaabuhu waa sir.**

Qoyska/Cabirka Qoyska.____

Dakhliga Qoyska: $____
☐ Todobaadle ☐ Sanadle
☐ Laba Todobaadle
☐ Bille

JINSIGA SHARCIGA AH
☐ LAB
☐ DHEGID

JINSIGA WAKHTIGAN
☐ LAB
☐ DHEGID

WAXA LAGUUGU YEEDHAYO (Ikhtiyaar):
____

AQOONSIGA JINSIGA
☐ LAB
☐ DHEGID
☐ NAAG JINSIGA BEDESHAY (Gabadh Nin Iska Dhigtay/FTM)
☐ NIN JINSIGA BEDELEY (Nin Naag Iska Dhigay (MTF)
☐ KHANIIS
☐ WAXKALE
☐ MA DOONAYO IN AAN SHEEGO

RABITAANKA JINSIGA
☐ JINSI CAADI AH
☐ KHANIISAD, KHANIIS, ama KHANIIS
☐ LABEEB
☐ WAX KALE
☐ MAGARANAYO
☐ MA DOONAYO IN AAN SHEEGO

XAALADA GURIGA Ma Bilaa Guri Ayaad Tahay? ☐ HAA ☐ MAYA
Hadii aad bilaa guri tahay, miyaad: ☐ Dul Saar ( la nool cid kale) ☐ Hoy ☐ Wadada ☐ Kala guur ☐ Lama Garanayo

**FARMASIGA AAD DOOR BIDO**

| MAGACA FARMASIGA | GOOBTA FARMASIGA |
|---|---|
| | |

**MACLUUMAADKA XIDHIIDHKA**

| MAGACA | XIDHIIDHKA | LAMBARKA TALEEFANKA |
|---|---|---|
| | | |

**MACLUUMAADKA CIDA MASUULKA AH (Wixii bukaan ah ee 18 jir ka yar waa inuu yeelayahay cid ka masuul ah)**

☐ Bukaanka (18 jir ama ka wayn) ☐ Waalidka Gacanta Ku Haya ☐ Koriye (cadaynta xaalada sharci ee loogu baahan yahay daawaynta)

| MAGACA SADEXAAD | MAGACA KOWAAD | Aabaha |
|---|---|---|
| | | |

| CINWAANKA JIDKA | MAGAALADA | GOBOLKA | ZIP-KA |
|---|---|---|---|
| | | | |

| TAARIIKHDA DHALASHADA | TALEEFANKA GURIGA |
|---|---|
| | |

**MACLUUMAADKA CAYMISKA ILKAHA**

☐ **Waxa aan haystaa wakhti xaadirkan caymiska ILKAHA (eeg hoos)**
☐ **MA haysto wakhti xaadirkan caymiska ILKAHA**
☐ **Ma doonaysaa inaad dalbato MIISAANKA HEERKA**

Magaca Caymiska Ilkaha: ____

Caymiska/Lambarka Aqoonsiga: ____

☐ **Waxa aan haystaa wakhti xaadirkan caymiska ILKAHA oo labaad (eeg hoos)**

Magaca Caymiska Ilkaha: ____

Caymiska/Lambarka Aqoonsiga: ____

**MACLUUMAADKA CAYMISKA CAAFIMAADKA**

☐ **Waxa aan haystaa wakhti xaadirkan caymiska CAAFIMAADKA (eeg hoos)**
☐ **MA haysto wakhti xaadirkan caymiska CAAFIMAADKA**
☐ **Ma doonaysaa inaad dalbato MIISAANKA HEERKA**

Magaca Caymiska Caafimaadka: ____

Caymiska/Lambarka Aqoonsiga: ____

☐ **Waxa aan haystaa wakhti xaadirkan caymiska CAAFIMAADKA oo labaad (eeg hoos)**

Magaca Caymiska Caafimaadka: ____

Caymiska/Lambarka Aqoonsiga: ____

Community Health Centers

# 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 ☐ Good Health ☐ Winooski ☐ Essex

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

LAST NAME | FIRST NAME | MIDDLE INITIAL | 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

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

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

Family/Household Size: _____

Household Income: $ _____
☐ Weekly ☐ Annually
☐ Biweekly
☐ Monthly

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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# Ogolaanshaha Daawaynta iyo Ogolaanshaha Bixinta Macluumaadka Caafimaad

## I. Ogolaanshaha Daawaynta

Waxa aan halkan ku ogolaaday daawaynta naftayda, ama bukaanka magiciisa la sheegey (oo aan anigu u ahay waalidkii ama koriyihiisa sharciga ah oo xaq u leh inuu u ogolaado daawaynta bukaanka magiciisa lagu sheegey kor) Xarumaha Caafimadka Bulshada (CHC). Daawaynta waxaa kamid ah shaybaadhka, baadhitaanka iyo daawaynta caafimaad, daryeelka ilkaha; adeegyada bulshada; caafimaadka iyo/ama shaybaadhka caafimaadka maskaxda ama khamrida, qiimaynta, xanuunka iyo daawaynta, adeegyada iyo adeegyada dhakhtarka cilmi nafsiga.

## II. Ogolaanshaha bixinta macluumaadka caafimaadka:

Waxa aan ogolaaday isticmaalka CHC iyo in la siiyo dad iyo hay'ado ka baxsan CHC duwaanadayda (ama kuwa bukaanka la sheegey magiciisa ee aan waalidka ama koriyaha u ahay) caafimaad, daryeelka ilkaga, khamrida iyo mukhaadaraadka, caafimaadka maskaxda, dhakhtarka cilmi nafsiga iyo daawaynaha kale iyo caafimaadka ("macluumaadka cafimaadka") ee CHC wixii ah ujeedada soo socota:

### A. Isticmaalka macluumaadka caafimaadka ee ama loogu talo geley daawaynta, bixinta iyo shaqada daryeelka caafimaad ee CHC:

- Bixinta daawaynta shaqaalaha CHC:
- Qabashada shaqooyinka daryeelka caafimaad, oo waxaa ku jiwa, hantidhawrka dhaqaale ama tayada caymiska iyo/ama tobobarka.
- Toos ugu dalicida shirkadaada caymiska ah lacagta
- Lacagta adeegyada ay bixisay CHC. CHC waxaa loo ogol yahay inay siiso adeegyada daryeelka caafimaadka iyo inay siiso duwaanada caafimaadka la bixiyay shirkadaha caymiska, caymiska gunada shaqaalaha ama hay'adaha kale ee bixiya adeegyada caafimaadka, iyo macluumaadka caymiska ee ugu danbeeya ee kale ee ku jira faylka CHC hayso.

### B. Bixinta macluumaadka caafimaadka ee qoyska ama hay'adaha ka baxsan wixii ah ujeedo daawaynta CHC:

- CHC waxay sisaa dhaaman macluumaadka caafimaadka bixiyayaasha caafimaadka ee kale ama hay'adaha ku jira daryeelkaaga. Tan waxaa kamid ah duwaanada caafimaadka ee hore ee hay'adaha banaanka ah. (Macluumaadka si shakhsi ahaaneed ay tahay in loo bixiyo waa in loo gudbiyo dhamaan qoyska, asxaabta, ama shakhsiyadka kale ee doonaya inay galaan macluumaadkaaga Duwaanka Caafimaadka.)

# Consent for Treatment and Consent to Release Health Information

## 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 (CHC). 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 health information:

I consent to the use within CHC and the disclosure to persons or organizations outside of CHC 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 CHC for the following purposes:

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

- Providing treatment by CHC staff.
- Conducting health care operations, including financial or quality assurance audits and/ or training.
- Bill your insurance company directly
- Payment for services provided by CHC. CHC is authorized to obtain payment for health care services and can provide health records to insurance companies, workers compensation insurers or other agencies that pay for health services, or other updated insurance information on file with CHC.

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

- CHC is authorized to provide all health information to other health providers or agencies who participate in your care. This includes past medical records from outside organizations. (An Individual release of information must be submitted for all family, friends, or other persons that you wish to access your Medical Record information.)

## III. Assignment of Benefits

I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.

I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.

I understand I am responsible for any unpaid balances incurred because of my care at CHC.

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

A copy of the CHC payment expectations is available per your request.

## III. Ku Qorida Gunooyinka

Waxa aan u ogolaaday CHC inay ku dalacdo oo ay si toos ah uga hesho lacagta Medicaid/Medicare ama wixii caymis ah ee adeegyada la i siiyay.

Waxa aan halkan ku saxeexayaa in CHC ay dhamaan lacagta Medicaid, Medicare, ama wixii kale ee caymiska caafimaadka ah ee daryeelka caafimaadka, ee ay i siisay CHC.

Waxa aan fahansanahay in aan ka masuul ahayn wixii baaqi lacag ah ee aan galo ee daryeelkayga CHC.

Waxa aan fahansanahay in, ilaa inta aan ogahay, macluumaadka deegaanka ee aan bixiyay ay yihiin run oo sax yihiin**.**

Nuqulka filashooyinka lacagta CHC waxaa la heli karaa marka la dalbado.

## IV. Joojinta iyo xadidaada ogolaanshahan:

**A.** Wax aaan fahamsanahay in aan xaq u leeyahay in aan joojiyo ogolaanashahan wakhtiga kasta iyada oo qoraal ah, joojinta ogolaanshahan ma saamayn doono wixii talaabooyin ah ee ay qaaday CHC iyada oo ka duulaysa ogolaanshahan kahor inta aan la joojin. Hadii aan hore u joojiyay, ogolaanshahan waxa uu ku eeg yahay taariikhda soo socda: _____. Hadii aan midna la sheegin, ogolaanshahan waxa uu ku eeg yahay sadex sano kadib taariikhda ugu danbaysa ee adeegyada la i siiyo.

**B.** Waxa aan fahansanahay in aan dalban karo xadidaado isticmaalka ama bixinta macluumaadkayga caafimaad wixii ujeedo lagu sheegey ogolaanshahan iyo in CHC ay ogolaan karto ama ayna ogolaanaynin dalabka. Waxa aan fahansanahay in marka laga tago wixii xadidaado ah ee isticmaal ama bixin macluumaadka caafimaad ee lagu heshiiyay, CHC inayna siinin adeegyada adiga (ama bukaanka lagu sheegey magiciisa kor) iyada oo aan la heynin ogolaanshe saxeexan.

**C.** Waxa aan akhriyay Ogolaanshaha Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaad oo aan fahmay oo aniga oo og ayaan ogolaadan ogolaanshaheeda.

Waxaan xaqiijinayaa in la i siiyay adeegyada luuqada kahor inta aanan saxeexin foomka Ogolaanshahan Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaadka.

LOO BAAHAN YAHAY

Magaca Bukaanka: _____ Taariikhda Dhalashada: _____
Saxeexa Bukaanka: _____ Taariikhda: _____
Waalidka/Koriyaha: _____
Saxeexa Waalidka/Koriyaha: _____ Taariikhda: _____

## IV. Termination and restrictions of this consent:

**A.** I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____. If none is indicated, this consent will end three years after the last date of services to me.

**B.** 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 CHC may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHC will not be able to provide services to you (or the named patient) without this signed consent.

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

I confirm that language access services were provided to me before I signed this Consent for Treatment & Consent to Release of Health Information form. ☐

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**

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# ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge and accept the Notice of Privacy Practices at the Community Health Centers of Burlington.

I recognize I can view a copy of the Privacy Practice at www.chcb.org/forms/ or obtain a paper copy at any CHC location.

I understand that the Privacy Practice is in accordance with the Health Insurance Portability and Accountability Act of 1996 (also known as, "HIPAA".)

Patient Name_____ Date of birth_____

Signature_____ Date_____

or

Signature of Guarantor / Personal Health Representative _____

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# QIRAALKA HELITAANKA WARGELINTA NIDAAMKA SIRTA

Waxa aan halkan ku qirayaa oo aanku aqbaley Wargelinta Nidaamka Sirta Xarumaha Caafimadka Bulshada ee Burlington.

Waxa aan aqoonsaday oo aan akhriyay nuqulka Nidaamka Sirta ah ee ku jira www.chcb.org/forms/ ama waxa aan heley nuqul waraaqo ah oo yaalay CHC.

Waxa aan fahansanahay in Nidaamka Sirta ah uu waafaqsan yahay Sharciga La Xisaabtanka iyo Qaadista Caymiska Caafimaadka ee 1996 (sidoo kale loo yaqaan, "HIPAA".)

Magaca Bukaanka_____ Taariikhda dhalashada_____

Saxeexa_____ Taariikhda_____

ama

Saxeexa Damiinka / Wakiilka Caafimaadka Shakhsi Ahaaneed _____