Community Health Centers

FOMU YA USAJIWA WA MGONJWA

Imethibitishwa na:

TAREHE REK/IMEINGIZWA:___/___/____

VIFUPISHO VYA MFANYAKAZI:_____

AINA YA MIADI/MATUMIZI YA WAFANYAKAZI PEKEE ☐ **MATIBABU** ☐ **MENO**

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

TAARIFA ZA MGONJWA *TAFADHALI KAMILISHA (Jaza) fomu yote kwa Kalamu Nyeusi au Buluu Pekee*

JINA LA MWISHO	JINA LA KWANZA	VIFUPISHO VYA KATI	JINA LA UTANI/JINA LILILOCHAGULIWA

ANWANI YA MTAA	JIJI	JIMBO	ZIP

NAMBA YA HIFADHI YA JAMII #	TAREHE YA KUZALIWA	SIMU YA NYUMBANI	SIMU YA MCHANA	SIMU YA MKONONI

ANWANI YA BARUA PEPE

NJIA UIPENDAYO YA MAWASILIANO

☐ SIMU ☐ BARUA PEPE ☐ UJUMBE WA MAANDISHI

HALI YA NDOA

☐ Sijaoa/Sijaolewa ☐ Tumetengana ☐ Nimeoa/Nimeolewa ☐ Mjane ☐ Tumetalikiana ☐ Umoja wa Raia

JAMII

☐ Mmarekani-Mwafrika ☐ Mmarekani Asilia ☐ Mmarekani-Muasia ☐ Mkazi wa Visiwa vya Pasifiki ☐ Mzungu/Mweupe ☐ Jamii mchanganyiko

Lugha ya Kwanza kama Sio Kiingereza:_____

Je, Unahitaji Huduma za Wakalimani? ☐ NDIYO ☐ HAPANA

Kabila/Asili: ☐ Kihispania ☐ Sio Kihispania

Daktari wa Huduma za Msingi

MFANYAKAZI WA KILIMO

☐ Mhamiaji ☐ Msimu

Je, Wewe ni Mstafu wa Jeshi La Marekani?

☐ Ndiyo ☐ Hapana

TAARIFA ZA FEDHA ZA FAMILIA

Tukiwa kama Kituo cha Afya ambacho kinapokea ufadhili wa Serikali Kuu, tunatakiwa kukusanya taarifa hii. Majibu yote ni siri.

Ukubwa wa Familia/Kaya:_____

Mapato ya Kaya: $_____

☐ Kila Wiki ☐ Kila Mwaka ☐ Kila Baada ya Wiki Mbili ☐ Kila Mwezi

JINSIA YA KISHERIA

☐ MWANAUME ☐ MWANAMKE

JINSIA YA SASA

☐ MWANAUME ☐ MWANAMKE

VIWAKILISHI (Hiari)

_____

UTAMBULISHO WA KIJISHIA

☐ MWANAUME ☐ MWANAMKE ☐ NIMEBADILI JINSIA MWANAUME (Mwanamke-kuwa-Mwanaume/FTM) ☐ NIMEBADILI JINSIA MWANAMKE (Mwanamke-kuwa-Mwanamke/MTF) ☐ MSENGE/MSAGAJI ☐ NYINGINE ☐ NACHAGUA KUTOJIBU

MUELEKEO WA KINGONO

☐ ULIOZOELEKA au ANAYEVUTIWA NA JINSIA NYINGINE ☐ MSAGAJI, MSENGE au ANAYEVUTIWA NA JINSIA MOJA ☐ ANAYEVUTIWA NA JINSIA MBILI ☐ KITU KINGINE ☐ SIJUI ☐ NACHAGUA KUTOJIBU

HALI YA MAKAZI Je, Wewe Huna Makazi? ☐ NDIYO ☐ HAPANA

Kama huna makazi: ☐ Mnabebana (unaishi na watu wengine) ☐ Makazi ☐ Mtaani ☐ Mpito ☐ Haijulikani

DUKA LA DAWA UNALOPENDELEA

JINA LA DUKA LA DAWA	ENEO LA DUKA LA DAWA

MAWASILIANO YA DHARURA

JINA	UHUSIANO	NAMBA YA SIMU

TAARIFA YA UPANDE UNAOHUSIKA (Mgonjwa yeyote mwenye umri chini ya miaka 18 lazima awe na upande unaohusika)

☐ Mgonjwa (chini ya miaka 18) ☐ Mzazi Mlezi ☐ Mlezi (uthibitisho wa hali ya kisheria inahitajika kwa ajili ya matibabu)

JINA LA MWISHO	JINA LA KWANZA	MI

ANWANI YA MTAA	JIJI	JIMBO	ZIP

TAREHE YA KUZALIWA	SIMU YA NYUMBANI

TAARIFA ZA BIMA YA MENO

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

☐ **Kwa sasa SINA bima ya MENO**

☐ **Ningependa kutuma maombi ya KIWANGO CHA PUNGUZO LA ADA**

Jina la Bima ya Meno:_____

Sera/Namba ya Kitambulisho_____

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

Jina la Bima ya Meno:_____

Sera/Namba ya Kitambulisho_____

TAARIFA YA BIMA YA MATIBABU

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

☐ **Kwa sasa SINA bima ya MATIBABU**

☐ **Ningependa kutuma maombi ya KIWANGO CHA PUNGUZO LA ADA**

Jina la Bima ya Matibabu:_____

Sera/Namba ya Kitambulisho_____

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

Jina la Bima ya Matibabu:_____

Sera/Namba ya Kitambulisho_____

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: _____

Community Health Centers

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Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya

I. Idhini ya Matibabu

Ninatoa idhini yangu ya matibabu kwa ajili yangu mwenyewe, au kwa ajili ya mgonjwa aliyetajwa (ambaye mimi ni mzazi au mlezi halali ambaye ana haki ya kukubali matibabu ya mgonjwa aliyetajwa) kwa Vituo vya Afya vya Jamii (CHC). Matibabu yanaweza kujumuisha uchunguzi wa afya, utambuzi, matibabu, huduma za meno, huduma za kijamii, afya ya akili au uchunguzi wa matumivi ya madawa ya kulevya na pombe, tathmini, utambuzi na matibabu, na huduma za afya ya akili.

II. Idhini ya kutoa taarifa za afya

Ninakubali CHC kutumia kumbukumbu zangu (au za mgonjwa aliyetajwa ambaye mimi ni mzazi au mlezi wa kisheria) za matibabu, meno, matumizi ya madawa ya kulevya na pombe, afya ya akili, ugonjwa wa akili na matibabu mengine ("taarifa za afya") ndani ya CHC na kuzitoa kwa watu au mashirika nje ya CHC kwa madhumuni yafuatayo:

A. Matumizi ya taarifa za afya ya CHC kwa ajili ya matibabu, malipo, na shughuli za huduma za afya:

- Kutoa matibabu kunakotekelezwa na wafanyakazi wa CHC.
- Uendeshaji wa shughuli za huduma za afya, ikiwemo ukaguzi na/au mafunzo ya fedha au udhibi wa ubora.
- Iandikie bili kampuni yako ya bima moja kwa moja
- Malipo ya huduma zinazotolewa na CHC. CHC imeidhinishwa kupata malipo ya huduma za afya na inaweza kuwasilisha taarifa za afya kwenye kampuni za bima, bima ya fidia kwa wafanyakazi au mashirika mengine ambayo hulipia huduma za afya, au taarifa nyingine mpya za bima kwenye faili la CHC.

B. Utoaji wa taarifa za afya kwa watu au mashirika nje ya CHC kwa ajili ya matibabu:

- CHC imeidhinishwa kutoa taarifa zote za afya kwa watoa huduma wengine wa afya au mashirika ambayo yanashiriki kukupatia huduma. Hii ni pamoja na taarifa za afya za zamani kutoka nje ya mashirika. (Utoaji wa mwisho wa taarifa lazima uwasilishwe kwa familia zote, marafiki, au watu wengine ambao ungetaka wapate taarifa zako za matibabu.)

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. Ugawaji wa faida

Ninairuhusu CHC kiandikia bili na kupokea malipo moja kwa moja kutoka Medicaid/Medicare au watoa huduma wengine wa bima kwa huduma nilizopewa.

Kwa hiyo ninaipatia CHC malipo yote kutoka Medicaid, Medicare, au sera yoyote ya bima ya afya kwa huduma za afya, nilizopewa na CHC.

Ninaelewa kwamba nina wajibu wa kulipa kiasi chochote ambacho hakijaliwa kinachotokana na huduma nilizopatiwa na CHC.

Ninaelewa kwamba, kwa ufahamu wangu wote, taarifa za kidemografia nilizotoa ni za kweli na sahihi**.**

Nakala ya matarajio ya malipo ya CHC inapatikana utakapoiomba.

IV. Ukiukaji na mipaka ya idhini hii:

A. Ninaelewa kwamba nina haki ya kufuta idhini hii wakati wowote kwa maandishi, kufuta idhini hii hakutaathiri hatua zozote zilizochukuliwa na CHC kwa kutegemea idhini hii kabla ya kufutwa. Ikiwa haijafutwa hapo awali, idhini hii itaisha tarehe ifuatayo: _____. Ikiwa hakuna kilichobainishwa, idhini hii itaisha miaka mitatu baada ya tarehe ya mwisho kupatiwa huduma.

B. Ninaelewa kwamba ninaweza kuomba kuweka mipaka ya matumizi au utoaji wa taarifa zangu za afya kwa madhumuni yaliyoelezewa katika idhini hii na kwamba CHC inaweza kukubali au kukataa ombi hilo. Pia ninaelewa kwamba isipokuwa kwa mipaka hiyo ya matumizi au utoaji wa taarifa za afya ambayo CHC inaikubali, CHC haitaweza kukupa huduma (au mgonjwa aliyetajwa) bila idhini hii iliyosainiwa.

C. Nimeisoma Idhini hii ya Matibabu na Idhini ya Kutoa Taarifa za Afya, na ninaelewa na kujua maudhui ya idhini hii.

Ninathibitisha kuwa huduma za matumizi ya lugha nilipatiwa kabla ya kusaini fomu hii ya Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya.

INATAKIWA

Jina la Mgonjwa:_____ Tarehe ya Kuzaliwa_____
Sahihi ya Mgonjwa:_____ Tarehe:_____
Mzazi/Mlezi:_____
Sahihi ya Mzazi/Mlezi:_____ Tarehe:_____

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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KUKIRI KUPOKEA TAARIFA YA UTEKELEZAJI WA FARAGHA

Hivyo basi, ninatambua na kukubali Taarifa ya Utekelezaji wa Faragha katika Vituo vya Afya vya Jamii vya Burlington.

Ninatambua kwamba ninaweza kutazama nakala ya Utekelezaji wa Faragha kwenye www.chcb.org/forms/ au pata nakala ya karatasi kwenye kituo chochote cha CHC.

Ninaelewa kwamba Utekelezaji wa Faragha hii ni kwa mujibu wa Sheria ya Bima ya Afya na Uwajibikaji ya 1996 (pia inajulikana kama, "HIPAA".)

Jina la Mgonjwa_____ Terehe ya kuzaliwa_____

Sahihi_____ Tarehe_____

au

Sahihi ya Mdhamini / Mwakilishi Binafsi wa Afya _____