REGISTRATION FORM MR#:_____

PATIENT INFORMATION

Legal last name: Legal first: Middle:			Today's Date:	
Chosen first name:	Date of Birth:		S.S.N:	
Billing address:		Apartment No:	Cell phone No:	**Primary contact number** ❑ Cell ❑ Home ❑ Work
City:	State:	Zip code:	Home phone No:	
Marital Status:	Religion:		Work Phone No:	
Email address: ***Must be 18 years of age or older***				

Pronoun: ❑ He ❑ She ❑ They ❑ Ze ❑ Not listed ❑ No preference

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank you.

Sex assigned at Birth

❑ Male
❑ Female
❑ Intersex
❑ Decline to Answer

Gender Identity

❑ Male
❑ Female
❑ Trans Male
❑ Trans Female
❑ Genderqueer/nonconforming
❑ Something Else
❑ Decline to Answer

Sexual Orientation

❑ Lesbian
❑ Gay
❑ Bisexual
❑ Queer
❑ Straight
❑ Something Else
❑ Decline to Answer

Race *Select all that apply*

❑ American Indian/Alaska Native
❑ Black/African American
❑ White/Caucasian
❑ Hispanic/Latino

Asian:
❑ Japanese ❑ Asian Indian
❑ Chinese ❑ Vietnamese
❑ Filipino ❑ Other
❑ Korean

Native Hawaiian/Pacific Islander:
❑Native Hawaiian
❑Samoan
❑ Guamanian/Chamorro
❑ Other Pacific Islander
❑ Decline to Answer

Housing Status

❑ Stable housing
❑ Homeless
Select which best applied:
❑ Street
❑ Shelter
❑Transitional
❑Doubling up
(not paying rent)

❑ Decline to Answer

Preferred spoken/written Language:

❑ English ❑ Spanish
❑ American Sign Language
❑ Other:

Language interpretation services needed?

❑ No

❑ Yes, Language:

Ethnicity

❑ Non-Hispanic/Latino
❑ Dominican
❑ Cuban
❑ Mexican/Chicano/a
❑ Puerto Rican
❑ Other Hispanic/Latino
❑ Decline to Answer

Deaf/HOH? ❑ Yes ❑ No
Visually Impaired? ❑ Yes ❑ No

Do you have a non- AHI primary care provider that you want to continue to see?
❑ No ❑ Yes, Name: _____

PATIENT EMPLOYMENT			
Employer:		Occupation:	
Employment Status (Full-Time/Part-Time/Unemployed):		Employment date:	
Address:		City:	Zip code:
Veteran? ❑ Yes ❑ No		Migrant Worker? ❑ Yes ❑ No	
Additional Information			
1	Preferred Pharmacy:		
2	Preferred Pharmacy:		

INCOME	
Anticipated annual household income for this year:	Total # of people living in household, including yourself:

EMERGENCY CONTACT		
Contact Name:	Contact Phone No:	Relationship to patient:

INSURANCE INFORMATION (Please give your insurance card to the Patient Services Representative)			
❑ Insurance is through an employer			
❑ Patient is own guarantor/Related to guarantor			
Name:	Birth date:	Sex:	Relationship to Patient:
Phone No:	Address (If different)	City:	Zip:
Primary Insurance			
Carrier Name:	Insured's name:		Insured's birth date:
Sex listed in health plan insurance: ❑ Male ❑ Female	Policy No:	Group No:	Co- payment: $
Guarantor Demographics			
❑ Patient is own guarantor			
Name:	Birth date:	Relationship to Patient:	Phone No:
Address (If different)		City	Zip:

Secondary Insurance			
Carrier Name:	Insured's name:	Insured's birth date:	
Sex listed in health plan insurance: ❑ Male ❑ Female	Policy No:	Group No:	Co- payment: $
Guarantor Demographics			
❑ Patient is own guarantor			
Name:	Birth date:	Relationship to Patient:	Phone No:
Address (If different)		City:	Zip:
How did you first learn of Anchor Health Initiative?			
❑ Friend/Patient	❑Referral	❑ Health Fair/Presentation	❑ Website/Internet
❑ Brochure/Ad	❑ TV/Radio/Print Media	❑ Facebook/Social Media	❑ Other
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Anchor Health Initiative or insurance company to release any information required to process my claims.			
X _____ Patient Signature Date			

Patient privacy is of the utmost importance to us at AHI. We recognize that this can be essential to members of the LGBTQ+ community in order to remain safe and receive adequate healthcare. We utilize Epic/MyChart as our electronic health record. This system is integrated with Yale New Haven Health System. If you have ever been to a facility in the YNHHS network, there may be contact information in the Epic system from previous facilities you have been to. We will only use the information provided in this registration packet to contact you. Please use the space below to inform us of any privacy concerns you may have. (e.g. no mail of any kind, no text messages for appointment reminders, do not leave voicemails). Please speak with your medical provider if you have concerns with certain information being added to your medical record such as gender identity, sexual orientation, diagnosis of gender dysphoria, etc.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights
At Anchor Health Initiative Corp., you have the right to:

- Considerate and respectful care in a safe, comfortable environment
- Personal privacy and confidentiality
- Be treated with dignity
- Know the names of health care providers and their role in your care
- Treatment by compassionate, skilled, qualified health care professionals
- Be informed about and participate in your care and treatment plans
- Be free from all forms of abuse or harassment
- Refuse treatment as allowed by law
- Request medically appropriate and necessary treatment
- Proper assessment and management of your pain or discomfort
- Request an interpreter
- Review and obtain copies of your medical records
- Receive treatment in an environment that is sensitive to your beliefs, values, and culture
- Be informed of the care you will need after the discharge
- Receive information about and an explanation of your bill
- Express a complaint or grievance by contacting the Patient Relations Coordinator at (860) 550-7500 ext. 6263
- Contact the following agencies if you are not satisfied with the outcome of your grievance:
    - Connecticut Department of Public Health
      410 Capitol Avenue
      Hartford, CT 06134-308
      Phone: (860) 509-7400, (800) 842-0038 TTY: (860) 509-7191
      www.dph.state.ct.us
    - Joint Commission One Renaissance Boulevard
      Oakbrook Terrace, IL 60181
      Phone: (800) 994-6610
      www.jcaho.org

Patient Responsibilities
At Anchor Health Initiative Corp., you have the responsibility to:

- Give us complete information about your medical history, including any medications you may be taking
- Tell us what you need. If you do not understand something, ask questions
- Participate in your care
- Follow our guidance as we try to help you get better
- Tell us about your concerns
- Be considerate of the rights of others - - patients and staff
- Keep appointments and be on time
- Share with us information about insurance so that we will be best able to help you pay your bill

PATIENT RIGHTS AND RESPONSIBILITIES (Cont'd)

Patient Code of Conduct

At Anchor Health Initiative Corp., we are committed to providing all patients, staff, and visitors with a safe and secure environment. All patients and visitors are required to follow this code of conduct at all times:

- Treat others in a respectful, dignified, and considerate manner
- Refrain from any behavior that may be disruptive to others or the operation of the facility
- Refrain from any form of verbal or physical abuse of others
- Refrain from any form of sexual harassment of others
- Refrain from using, selling, or distributing any alcohol, illicit drugs, or drug paraphernalia
- Do not arrive on the premises under the influence of alcohol or drugs
- Do not lie in order to obtain prescription medications and do not sell or distribute medications prescribed for you
- Abide by the laws of the city and state
- Keep the environment clean
- Follow the directions of staff especially in an emergency

PATIENT CONSENT FORM

MR#:_____

ALL PATIENTS: PLEASE READ AND SIGN AT #1, #2, & #3 PRIOR TO FIRST VISIT

1) CONSENT FOR TREATMENT:

I,_____(**please print name**) am voluntarily seeking medical care and treatment from Anchor Health Initiative ("AHI") and give permission to the medical, mental, and oral health staff of AHI to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

X_____ ____/____/____ X_____ ____/____/____

Patient Signature ***Date*** ***Guardian/Parent Signature*** ***Date***

2) CONSENT TO BILL:

√ If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with AHI's Patient Financial Policy;

√ If my insurance is accepted, I authorize payment of benefits to AHI or will reimburse AHI if I am paid directly by my carrier;

√ I hereby authorize that AHI may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;

√ I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;

√ I understand that my insurance may not cover all charges deemed medically necessary by AHI;

√ I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly to those services.

Cancellations of appointments/no-show:

√

- When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.
- If for any reason you need to cancel an appointment, please notify our office as a soon as possible.
- After 3 no show it will be a 6 month wait for an appointment.
- After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

X_____ ____/____/____ X_____ ____/____/____

Patient Signature ***Date*** ***Guardian/Parent Signature*** ***Date***

3) Patient Rights and Responsibilities:

√ I have received a copy of the **AHI Patient Rights and Patient Responsibilities**

X_____ ____/____/____ X_____ ____/____/____

Patient Signature ***Date*** ***Guardian/Parent Signature*** ***Date***

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain, and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

I. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted;
II. Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to our office;
III. Appeal a denial of access to your protected health information except in certain circumstances;
IV. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
V. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
VI. Obtain an accounting of disclosures of your health information as required to be maintained by Jaw by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
VII. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
VIII. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

I. Maintain the privacy of your health information as required by law;
II. Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this Notice;
III. Notify you if we cannot accommodate a requested restriction or request; and
IV. Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change. we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your infom1ation, you may contact our office administrator.

Additionally, if you believe your privacy rights have been violated., you may file a written complaint at our office by delivering the written complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is 200 Independency Ave. S.W. Washington, D.C., 20201, phone# 1- **877-696-6775, http://HHS.gov**

L We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

2. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose the FDA your protected health information relating to adverse events with respect to products and product defects or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal Law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: *05/11/2017*

MR#:_____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE PRIVACY PRACTICES

I acknowledge that I have received a copy of the Anchor Health Initiative **HIPAA Notice of Privacy Practices.**

_

_____

Patient Name (please print name)

X_____ _____

Patient Signature ***Date***

OR

_____

Personal Representative Name (please print name)

X_____ _____

Signature of Personal Representative ***Date***

Authority of Personal Representative to Sign for Patient (**check one**):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT

----------*Staff Use Only*----------

I tried to obtain written Acknowledgement by the noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgment.
__ A communication barrier prevented us from obtaining acknowledgement.
__ The individual was unwilling to sign.
__ Other: _____

_____ **X**_____ _____

Staff Member Name (please print name) ***Staff Member Signature*** ***Date***

OUR NO-SHOW POLICY HAS UPDATED- PLEASE REVIEW

Due to our increasing number of patients, we need to update our no-show policy to better accommodate everyone's care.

If you have 3 or more no-shows, you will not be able to make an appointment for 3 months or at the discretion of your medical provider.

If you cannot make it to your appointment, you must give our office 24-hour (to the hour) notice.

If you need to cancel a Monday appointment, you must let us know on Friday by your scheduled Monday appointment time. For example, if your appointment is on Monday at 3:00 PM, you must call our office to cancel no later than the previous Friday at 3:00PM.

If you do not notify our office 24 hours before your appointment that you cannot make it, or you do not show up,

you will be charged $50 if you have commercial insurance.

Please note, the only exceptions to this policy would be due to sudden illness, emergencies, or unexpected office closure such as those due to weather.

If you have barriers preventing you from making your appointments, please inform our front-desk staff or your health provider. We have people who can help address barriers like transportation.

I acknowledge that I have received a copy of the Anchor Health Initiative **No Show Policy.**

_

_____

Patient Name (please print name)

X_____ _____

Patient Signature ***Date***

OR

_____

Personal Representative Name (please print name)

X_____ _____

Signature of Personal Representative ***Date***

Application for Income-Based Discount **MRN:**_____

(Please note this form is optional)

Name_____ **Date of Birth:** _____
(Please Print) (MM/DD/YYYY)

Total annual income is $_____**Number of dependents** (Including Self) _____

Please check which financial documents you are providing:

___ Pay Stub
____ Tax Form
____ Bank Statement
____ Letter of Unemployment/Check Stub
____ Letter of Employment
____ Other (please explain): _____

If you are unable to provide documentation, check all that apply:

____ I do not have documentation today.
____ I get paid in cash
____ I do not get paychecks or pay stubs
____ I do not earn income
____ Other reason: _____

*****If your annual income does not match your documents, please explain why:**

____ I am employed for only part of the year (please explain): _____
____ My income changes from month to month (please explain): _____
____ Other reason (please explain): _____

I certify that I have provided all of my income information and that all of the above information is true and correct. I understand that this information is required to fulfill grant reporting purposes and will be used to determine eligibility for the Income Based Sliding Fee Scale at Anchor Health Initiative if I am uninsured. I also understand that if I have intentionally misrepresented my income, I will be asked to repay any discounts I have been given and may lose my eligibility for discounts in the future. I understand that false information may also lead to discharge from Anchor Health Initiative.

You may need to meet with an Insurance Navigator to determine eligibility before receiving a discount for some services.

I decline to provide my income information. I understand that this decision may affect my ability to receive sliding scale discounts for services I receive. _____ (Initial)

Signature_____ **Date**_____

To apply this income to previous service dates, the effective date is: _____

Review Of System Form

Anchor Health Initiative, Inc.

Healthcare focused on the Science of Gender, Sexuality, HIV and Infectious Diseases

Patient Name: Date:

Please check the boxes if you have had any of the following problems since your last visit:

General
Fever
Chills
Weight change

Eyes
Blurred vision
Double vision
Other:

Head
Headaches
Migraines
Other:

Psychiatric
Anxiety
Depression
Other:

Breast
Lumps
Tenderness
Swelling
Nipple discharge
Other:

Chest
Cough
Shortness of breath
Other:

Heart
High blood pressure
Chest pain
Irregular heart beat/palpitations
Other:

Gastrointestinal
Abdominal pain
Nausea
Diarrhea
Constipation
Other:

Musculoskeletal
Joint pain
Back pain
Muscle problems
Other:

Immunologic
Tuberculosis
Hepatitis
Recurrent infections
Other:

Ears
Pain
Hearing loss
Ringing in ears
Other:

Hematologic
Anemia
Easy bleeding
Other:

Endocrine
Excessive thirst
Excessive heat or cold
Other:

Renal
Kidney stones
Urinary tract infections
Discomfort with urination
Other:

Neurologic
Weakness
No stroke
No seizures
Numbness
Tingling
Other:

Pelvic
Penile discharge
Problem with erections
Problem with orgasm
Exposure to sexually transmitted infection
Painful periods
Vaginal discharge
Pelvic pain
LMP

Skin
Rashes
Skin complaints • Describe:

Patient Health Questionnaire – 2

Patient Name:_____ **Date of Visit:** _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than Half the days	Nearly Every day
1 - Little interest or pleasure in doing things	0	1	2	3
2 – Feeling down, depressed or hopeless	0	1	2	3