Client Registration

Equitas Health Care for All

Medical Record # *(For office use only)*

Legal Name* Last First Middle Initial **Preferred name:**

Legal Sex (please check one)* ☐ Female ☐ Male **Preferred pronouns:**

**While Equitas Health affirms the range of sexual orientation, gender identity and gender expression, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know so that we may address you as you wish.*

Date of Birth *Month Day Year* / /

Social Security #

State ID # or License #

Type of Visit: ☐ ***Non-HIV Primary Care*** ☐ ***HIV Care*** ☐ ***PrEP/PEP*** ☐ ***Behavioral Health***

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** Yes No	**Cell Phone** ( ) - **Ok to leave voicemail?** Yes No	**Work Phone** ( ) **Ok to leave voicemail?** Yes No	**Is it ok to leave appointment reminders? (check all that apply)** ☐ Home ☐ Cell ☐ Work

Local Address City State ZIP

Billing Address (if different from above) City State ZIP

Email address:

Occupation Employer/School Name Are you covered under school or employer's insurance? ☐ Yes ☐ No

Emergency Contact's Name Phone Number Relationship to you

If you are under 18, Equitas Health requires that you provide parent/guardian contact information.

Parent/Guardian Name Phone Number Relationship to you

How would you prefer to receive correspondence? (check one) ☐ Email ☐ Voicemail ☐ Mail ☐ Other _____

This information is for demographic and care purposes:

1.) What is your annual income?

_____

❑ No income

1a.) How many people (including you) does your income support?

_____

2.) Employment Status

❑ Employed full time
❑ Employed part time
❑ Student full time
❑ Student part time
❑ Retired
❑ Unemployed
❑ Other _____

3.) Racial Group(s) (check all that apply)

❑ African American / Black
❑ Asian
❑ Caucasian / White
❑ Native American / Alaskan Native / Inuit
❑ Pacific Islander
❑ Other _____

4.) Ethnicity:

❑ Hispanic/Latino/Latina
❑ Cuban
❑ Puerto Rican
❑ Mexican
❑ Other

5) Country of Birth

❑ USA
❑ Other _____

6.) Preferred Language (choose one:)

❑ English
❑ Español
❑ Français
❑ African (Specify:_____)
❑ 中文
❑ Other _____
❑ **I need an interpreter**

7.) Do you think of yourself as:

❑ Lesbian, gay, or homosexual
❑ Straight or heterosexual
❑ Bisexual
❑ Something else
❑ Don't know

8.) Relationship Status

❑ Married
❑ Partnered
❑ Single
❑ Divorced
❑ Other_

9.) Veteran Status

❑ Veteran
❑ Not a Veteran

10.) Referral Source

❑ Self
❑ Friend or Family Member
❑ Health Provider
❑ Emergency Room
❑ Ad/Internet/Media/ Outreach Worker/School
❑ Other _____

11.) What is your gender identity?

☐ Female
☐ Male
☐ Genderqueer
☐ Non-binary

12.) What was your assigned sex at birth?

☐ Female
☐ Male

13.) Do you identify as transgender?

☐ Yes
☐ No
☐ Don't know

Please turn over

Medical Consent for Treatment

Patient Name: _____ Date: _____

I hereby give my consent and authorize Equitas Health to treat any medical or mental health and/or substance use condition. The provider has explained my condition to me, the treatment procedures, and alternative methods of treating my condition. I understand that my provider will discuss any foreseeable risks of the treatment provided, including explaining that there may be undesirable results.

I authorize Equitas Health providers to perform any additional or alternative treatments which in their opinion are necessary.

I understand that Equitas Health operates a primary care practice that integrates behavioral health services. Meaning, behavioral health staff are part of my medical team and experience. I understand that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance obligation. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.

By signing below, I acknowledge that I have carefully read and fully understand this Medical Consent for Treatment and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical or mental health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I understand that Equitas Health may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and for quality improvement. I understand this information remain anonymous and confidential.
- I acknowledge that I have read and been given a copy of the Equitas Health “No Show” & Alternate Scheduling policy and procedure and Equitas Health has given me the chance to discuss my concerns and any questions concerning this policy.

I certify that the above information is true and correct. I have received a copy of Equitas Health‘s Notice of Privacy Practices and Patient Rights and Responsibilities. I have carefully read and understand both.

Patient Signature: _____ Date: _____