Patient Registration Form

Welcome to Equitas Health! Thank you for choosing us for your care. To help us serve you better, please complete this form. Several of the items below help us ensure that we are meeting the needs of all of our patients, so please be as thorough as you can. Let us know if you have any questions or if we can help you complete this form.

HOW CAN WE HELP YOU?

- ☐ Primary Medical Care
- ☐ HIV Medical Care
- ☐ HIV Testing
- ☐ STI Testing
- ☐ Gender-Affirming Care
- ☐ Post-Exposure Prophylaxis (PEP) (I was exposed to HIV)
- ☐ Pre-Exposure Prophylaxis (PrEP) (HIV prevention)
- ☐ Support Groups
- ☐ Dental
- ☐ Psychiatry
- ☐ Mental Health Counseling

First Name:	**Middle Initial:**	**Last Name:**
Preferred Name:		
Date of Birth: Month: Day: Year:	**Social Security Number:**	
Street Address:		**Apt. No.:**
City:	**State:**	**Zip:**

My housing is: ☐ Permanent ☐ Temporary ☐ I am experiencing homelessness

Are you worried about losing your housing? ☐ Yes ☐ No

We believe it is important to communicate with you, Equitas Health may send mail to the address listed above.

Phone Number: (XXX)XXX-XXXX

Cell Number: ____________________

Home Number: ____________________

Work Number: ____________________

☐ I consent to receiving text

Patient Portal:
The most secure way to communicate with us is through our patient portal. Please show us your identification and provide your email address.

Email address: ________________________

☐ I consent to email

Gender Identity:	**Sex Assigned at Birth:**	**Do you identify as transgender?**	**Sexual Orientation:**
☐ Man	☐ Male	☐ Yes	☐ Lesbian, Gay, Homosexual
☐ Woman	☐ Female	☐ No	☐ Straight, Heterosexual
☐ Trans Man	☐ Intersex	**Gender Pronouns:**	☐ Bisexual
☐ Trans Woman	☐ ______________	☐ He/Him/His	☐ Queer
☐ Genderqueer/Non-binary		☐ She/Her/Hers	☐ ________________
☐ __________________		☐ They/Them/Theirs	
		☐ ________________	

Race:	Ethnic Group:	Preferred Written/Spoken Language:
☐ Alaskan Native/Inuit ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White/Caucasian ☐ _________________	☐ Non-Hispanic/ Non-Latino Hispanic/Latino ☐ Cuban ☐ Puerto Rican ☐ Mexican/Mexican American ☐ Another Hispanic/Latino Spanish origin ☐ ______________	☐ English ☐ Spanish ☐ American Sign Language ☐ _________________________ **Do you need Language interpretation services?** ☐ No ☐ Yes, language ___________________

How much money do you earn in a year?	**Employment Status:**
$____________________ ☐ I do not have any income	☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ ___________________
How many people (including you) does your income support? __________________________________	**In the past 2 years, has seasonal or migrant farm work been your main source of income?** ☐ Migrant ☐ Seasonal ☐ Neither
To comply with Federal law, we are required to collect information about income and household size from all patients to determine the patient's income by the Federal Poverty Level.	**Veteran Status:** ☐ Veteran ☐ Not a veteran

Emergency Contact Information

First Name:	Last Name:	Relationship:
Cell Number:	**Work Number:**	
Home Number:		

Payment and Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.

Are you insured? ☐ Yes ☐ No	If you do not have insurance, you must meet with the Financial Counselor. You may be eligible for insurance or our sliding fee scale for services. To determine your eligibility, you must provide income, family size, and residency documentation. Until we receive your documentation, you will be responsible for the full fee for your services.

<table>
<tr><td>Out of Network</td><td colspan="3">Our providers may be out of network for your insurance. Choosing to get care with an out of network provider may mean you get charged for the full service and you will have to seek reimbursement from your insurer. Our registration staff can help you understand if our providers are in or out of your network.</td></tr>
<tr><td rowspan="7">Insurance Information:</td><td>Company:</td><td colspan="2">Identification Number:</td></tr>
<tr><td>Group Number:</td><td colspan="2">Contact Number (on back of card):</td></tr>
<tr><td colspan="2">In whose name is your insurance?
☐ Self
☐ Other

If “other”, please provide the subscriber’s information below</td><td>If private/commercial insurance:
☐ Employer-Paid
☐ Individual-Paid
☐ Other:______________________</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Social Security Number:</td></tr>
<tr><td colspan="3">Date of Birth:</td></tr>
<tr><td colspan="3">What is your relationship to the subscriber?</td></tr>
<tr><td rowspan="2">Secondary Insurance Information:</td><td>Company:</td><td colspan="2">Identification Number:</td></tr>
<tr><td colspan="3">Contact Number (on back of card):</td></tr>
<tr><td>Sex/Gender Marker with Insurance Company:</td><td>Equitas Health recognizes your gender identity. For insurance billing purposes, what sex/gender marker is on file with your insurance company?
☐ Male
☐ Female</td><td colspan="2">Is your legal name on your insurance card?
☐ Yes
☐ No, it’s listed as
________________________________</td></tr>
</table>

Medical Consent for Treatment, Payment and Use of Information

1. I give permission for Equitas Health to give me medical treatment. Treatment may include health screenings, diagnosis, dental care, social services, mental health and/or drug and alcohol screening/ assessments. I know treatment may include tests, injections, medications, etc., and there may be risks associated with treatment.

2. I allow Equitas Health to file for insurance benefits to pay for the care I receive. I understand that:

- Equitas Health may have to send my medical record information to my insurance company to collect payment.
- I must pay my share of the costs. Financial assistance is available for those who qualify.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I am responsible for providing correct and current insurance information.
- The signature on this form may be used on all insurance claim submissions.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- Equitas Health has students/residents being trained as doctors, nurses, therapists and other health care professionals who may help with my care. These individuals are under the supervision of licensed providers.
- Equitas Health may use information developed for and/or provided by clients to improve services. I understand this information is kept anonymous and/or confidential.

By signing below, I acknowledge that:

- The above information is true and correct.
- I have read and understand this Medical Consent for Treatment, Payment and Use of Information.
- I have been given a copy of, read and understand Equitas Health's Patient Rights and Responsibilities
- Equitas Health has given me a chance to talk about my concerns and answered all of my questions.

Signature:	**Date:**

Give completed form to Receptionist at your first visit.