6209 16th Avenue
Brooklyn, New York 11204
Tel: 718-234-0073 | Fax: 718-236-8456

21-10 Borden Avenue
Long Island City, New York 11101
Tel: 718-784-5696 | Fax: 347-649-0663

179 Jamaica Avenue
Brooklyn, New York 11207
Tel: 929-267-5354 | Fax: 929-267-5340

Intake Form

Last Name:	First Name:		Middle Initial:	
DOB:	Sex at Birth:		Social Security:	
Address:	City:		State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	

Race:	**Ethnicity:**	**Sexual Orientation:**	**Gender Identity:**
☐ Asian	☐ Hispanic/Latino	☐ Lesbian or Gay	☐ Male
☐ Native Hawaiian	☐ Not Hispanic/Latino	☐ Straight (Not Lesbian or Gay)	☐ Female
☐ Other Pacific Islander	**Marital Status:**	☐ Bisexual	☐ Transgender Male / Female to Male
☐ Black/African American	☐ Married (not separated)	☐ Something Else	☐ Transgender Female / Male to Female
☐ American Indian/Alaska Native	☐ Living Common Law	☐ Don't Know	☐ Other
☐ White	☐ Widowed	☐ Chose Not to Disclose	☐ Chose Not to Disclose
☐ More than one race	☐ Separated		
☐ Unreported/Refused to report race	☐ Divorced		
	☐ Single		

Medicaid No:		Medicare No:		Other Ins.:	

Are you a Student? ☐ Yes ☐ No | **Work:** ☐ Full-Time ☐ Part-Time ☐ Unemployed

Please enter the family size and the income with the corresponding pay period.

Family Size:	**Income** $	☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly** ☐ **Annually**

Did you ever serve in the military? ☐ Yes ☐ No	**Email Address:**
Seasonal Worker: ☐ Yes ☐ No	**Migrant Worker:** ☐ Yes ☐ No
Language(s):	**Interpreter Needed** ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No **If "Yes," please check all that apply below:**

☐ Living in a Homeless Shelter ☐ Living on the street ☐ Living in transitional housing

Other (Please specify):

Referred to clinic by (Please check ONLY one box):

☐ Doctor Hospital ☐ Other (Please specify):

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Emergency Contact:		Relationship:	

Address:		City:		State:		Zip	

Home Phone:		Work Phone:		Cell Phone:	

Please complete the following section if applicable:

Name of Program/House:

Address:

City State Zip

Phone:________________Fax:________________ Case Manager:____________________Extension: ________

Pharmacy Name:

Address:

City State Zip

Phone: ____ Fax: ____

Please complete the following section if applicable:

Psychiatric History: ☐ Yes ☐ No **If "Yes," please complete the information below:**

Psychiatric Diagnoses:___________________________Other Pertinent Diagnoses: ___________________________

Medications	Dosage	Frequency	Route

Allergies: ☐ Yes ☐ No **If "Yes," please list allergies:**

PPD Status (circle one): **+ − ?** Date: __________________

PLEASE ATTACH ANY HOSPITALIZATION/PSYCHIATRIC SUMMARIES OR REPORTS

Print Name:			
Signature:		**Date:**	
HCC Staff		**Appt. Date**	
		Appt. Time	

PLEASE NOTE: ALL ATTACHED CONSENTS MUST BE SIGNED

INFORMED CONSENT FOR TREATMENT

I hereby authorized the Health Care Choices, Community Health Center (HCC) to perform any of the following procedures as necessary to facilitate my diagnosis and treatment:

- **Physical Examination;** may include but not limited to the following: interviewing about and palpation or (examination or exploring by touching an organ or area of the body) or movement of skin & dermatology; head; ear; nose; sinuses & throat, face & neck; lungs & pulmonary; chest & cardiovascular; abdominal; hands; arms & lower limbs; reflexes; motor skills; back & spine; cranial nerves; genitalia; prostate & rectal exams; breast exams and nutritional exams

- ~~Common diagnostic procedures, e.g. collecting, samples of tissues or body fluids (e.g. by swabbing, physically providing, venipuncture, pap smear; laboratory testing; and images (x-ray).~~

- Lifestyle counseling and hygiene: promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities, nutritional counseling.

- Minor office procedures e.g., dressing a wound, ear cleansing, soaking foot and dental repair.

- Psychiatric evaluation and psychological counseling.

The staff at HCC has explained to my satisfaction above procedures and risks and benefits of the care I will receive and I have given the opportunity to ask questions about the treatment plan and procedures. I understand that my practitioner will answer any question I have, to the best of his/her ability. I recognize that there may be certain potential risks and benefits of the procedures I am receiving, as described below:

- **Potential Risks:** Embarrassment or fear related to disclosing sensitive information; temporary pain or discomfort related to touching or moving during physical examination; bleeding, bruising or pain related to drawing blood or treatment procedures; possible prescription drug side effects; inconvenience of lifestyle changes.

- **Potential Benefits:** Restoration of health and body's maximum function capacity; relief of pain and symptoms of disease; assistance in injury and disease recovery and management, and prevention of disease or its progression.

- **Confidentiality:** I understand that a record will be kept of the health services provided to me. This record will be kept confidential. I agree to let HCC release my health information to others as permitted by law for the purpose of treatment, payment, or HCC's health care operations.

- **Consent:** With this knowledge, I voluntarily consent to the above procedures. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I certify that I have read and fully understand this consent and the matters that have been explained to me.

Patient:) ______________________________ **Date Signed:)** ______________

I certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the patient and that I am signing freely and voluntarily.

Authorized Representative: ______________________________ **Relationship to Patient:** ______________

I attest that the patient/authorized representative has signed this Consent freely and voluntarily.

Witness: ______________________________ **Date Signed:** ______________

Relationship to Patient: ______________________________

Registration Form and Assignment of Benefits

Name: ____ Date:____/____/______
Last Name First Name

Date of Birth:______/______/__________ SSN:______-______-________ Male ◯ Female ◯

Address:__________________________Apt.______City_______________State______Zip Code________

Phone Number:____________________Cell Number (if different) ____________________

Current HCC Patient: Yes ◯ No ◯

Language: English ◯ Spanish ◯ French ◯ Mandarin ◯ Cantonese ◯ Other _____________

How would you like to receive health information? Electronic ◯ Paper ◯ In Person ◯

Email Address: ____________________________

Insurance Information

Insurance: Yes ◯ No ◯

Primary Insurance Name: ____

Policy Holder's Name:_________________________________Insurance ID Number: _______________

Secondary Insurance Name: ____

Policy Holder's Name (if different) _ Insurance ID Number: _

I hereby authorize direct remittance of payment of all insurance benefits, including Medicaid and Medicare, to HealthCare Choices for all covered services provided to me during all courses of treatment. I understand that I am financially responsible to HealthCare Choices for any charges not covered by insurance. It is my responsibility to notify HealthCare Choices of any changes in my insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by HealthCare Choices and/or my health insurance company if the submitted claims or any part of them are denied for payment.

I authorize HealthCare Choices to release or give any information and copies of my medical records needed by my insurance company(ies) to pay HealthCare Choices for their services. I acknowledge that in certain circumstances, insurance companies may send a check and/or Explanation of Benefits(EOB) for services provided by HealthCare Choices directly to me (the patient). In such cases, I agree to endorse and send such check and/or EOB to HealthCare Choices.

_____________________________________ _________________________ ____/____/______
Signature of Patient/Parent/Guardian Relationship to Patient Date

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New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Healthcare Choices (including its agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Healthcare Choices to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Healthcare Choices to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Sliding Fee Scale Application and Self Declaration Form

NAME: ____

ADDRESS: ____

PHONE NUMBER: ______________ SOCIAL SECURITY NO. (Optional)______________

This statement is a self-declaration of my family income and size. I will renew my application annually and understand that my discount may vary from year to year.

My annual household income is approximately $__________________ per year.

My income comes from the following sources and I will provide documentation of my income within 30 days:

- **Social Security**
- **Permanent Fund Dividends X ______**
- **Other Income __________________**
- **Public Assistance**
- **Wages**
- **I have no Income**

The following people reside in my household: **Print Please**

______________________________ **(Head of Household)** ______________
First Full Middle Last Date of Birth

______________________________ ____________ ______________
First Full Middle Last Relationship Date of Birth

______________________________ ____________ ______________
First Full Middle Last Relationship Date of Birth

______________________________ ____________ ______________
First Full Middle Last Relationship Date of Birth

______________________________ ____________ ______________
First Full Middle Last Relationship Date of Birth

To the best of my knowledge, this is a true statement as to my family size and its income. I further acknowledge that making a false statement is punishable under New York State Law.

____
Name Date

____
Staff Witness Date

____
CFO Date

GENERAL MEDICAL INFORMATION

1. When was the last time you saw your primary care doctor or any other doctor?

2. Do you have any medical problems? If yes, please list.

3. Are you taking any medications? If yes, please list.

4. Do you have any allergies to medicine or foods? If yes, please list.

5. Do you or have you ever used a controlled substance? If yes, please list with dates.

6. What pharmacy do you use for medications? Please include Name and address.

CONSENT FOR COMMUNICATION VIA TELEPHONE,COMPUTER or E-MAIL (Provider – Patient)

I, ________________________ hereby consent to have my provider, ____________, communicate with me or members of the staff, where appropriate or other physicians, nurse practitioners, providers and pharmacists via telephone, computer or e-mail regarding all aspects of my medical care and treatment.

I understand that e-mail may not be a confidential method of communication. I further understand that there is a risk that e-mail communications between my provider and me or members of my provider's office staff, or between my physician and other physicians, nurse practitioners, providers and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my provider and me or members of his/her office staff, or between my physician and other physicians, nurse practitioners, providers or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on e-mail.

Email Address: ______________________________________

Telephone Number: ______________________

______________________________ ______________________________
Patient Name (Print) **Date**

______________________________ ______________________________
Signature of Patient or Responsible Party **Relationship (if responsible party)**