Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly in BLACK ink only)

Legal Name* Last First Middle Initial | **Name used:**

Legal Sex (please check one)* ☐ Female ☐ Male | **Pronouns:**

**While Outer Cape Health Services recognizes a number of genders / sexes, 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.*

Date of Birth (mm/dd/yyyy) _____ / _____ / _____ | **Social Security #**

Contact Information

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	**Best number to use to leave results & messages?** ☐ Home ☐ Cell ☐ Work ☐ Other:

Mailing Address City State Zip Code

Address (if different from above) City State Zip Code

Email address | Would you like to register for the Patient Portal? ☐ Yes ☐ No

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, the Department of Public Health requires that you provide parent/guardian contact information.

Parent/Guardian Name Phone Number Relationship to you

Preferred Pharmacy

Pharmacy Name_____ **Address** _____

Insurance Information

Medical	Plan Name	Subscriber #	Insured Name
Secondary	Plan Name	Subscriber #	Insured Name
Vision	Plan Name	Subscriber #	Insured Name
Dental	Plan Name	Subscriber #	Insured Name

Permission to Speak/Share Information

I authorize disclosure of my healthcare information to the individuals listed below. I understand that this authorization is voluntary I understand that one disclosed by Outer Cape Health Services to such person(s), we can no longer ensure that the confidentiality of the information. I understand that this authorization will remain in effect until Outer Cape Health Services receives written notice from me to cancel it.

Name	Relationship	Phone Number

Demographic Information

This information is for demographic purposes only and will not affect your care. As a Federally Qualified Health Center, Outer Cape Health is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

1) What is your annual income?

$ _____

☐ No income

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 / Native Hawaiian
☐ Pacific Islander

4.) Ethnicity

☐ Hispanic/Latino/Latina
☐ Not Hispanic/ Latino/Latina

5) Preferred Language (choose one)

☐ English
☐ Spanish
☐ French
☐ Portuguese
☐ Hebrew
☐ Other _____

6) Do you think of yourself as:

☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to disclose

7) Marital Status

☐ Married
☐ Partnered
☐ Single
☐ Divorced
☐ Other _____

8.) Veteran Status

☐ Veteran
☐ Not a Veteran

9.) What is your gender?

☐ Female
☐ Male
☐ Genderqueer or not exclusively male or female
☐ Choose not to disclose

10) What was your sex assigned at birth?

☐ Female
☐ Male
☐ Choose not to disclose

11) Do you identify as transgender or transsexual?

☐ Yes
☐ No
☐ Don't know
☐ Choose not to disclose

Treatment, Payment and Data Agreement

Print Name: _____ **Date of Birth:** _____

- I hereby give my consent and authorize Outer Cape Health Services to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.
- I understand that Outer Cape Health Services operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and 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. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.
- I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.
- 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 authorize release of all information necessary to secure payments of benefits.
- I understand that Outer Cape Health Services may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I certify that the above information is true and correct. I have received a copy of Outer Cape's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature _____ **Date** _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order.