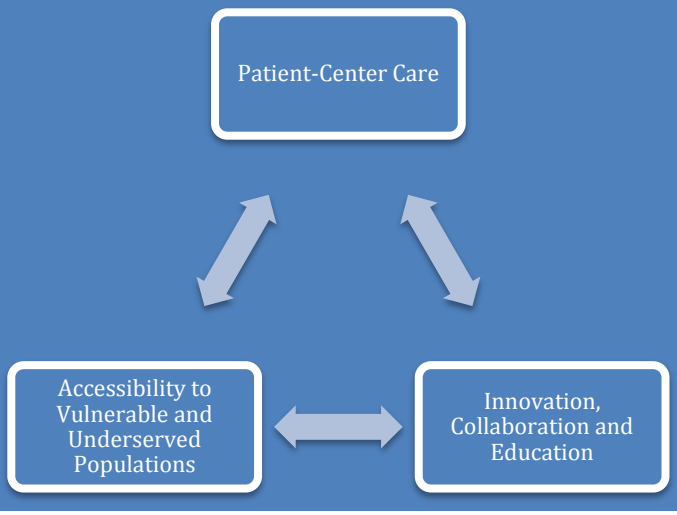
MONTGOMERY COLLEGE HEALTH CLINIC



Patient Information:

Today's Date:
Legal Name:
Chosen Name if different from legal name:
Mailing Address:

Phone Numbers:

Primary Contact Phone Number:

Method of Preferred Contact:

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. Our funders provided the options for some of these questions. Please help us to serve you by selecting the best answers that apply to these questions. Thank you.

What is your preferred pronoun:
☐He
☐She
☐They
☐Ze
☐A pronoun not listed
☐No pronoun preference

Preferred Spoken/Written Language:
☐English ☐Spanish ☐ASL ☐Other

Are language interpretation services needed? ☐ Yes ☐No

Ethnicity:

☐**Non-Hispanic/Latino**
☐**Dominican**
☐**Salvadoran**
☐**Mexican/Chicano/a**
☐**Peruvian**
☐**Puerto Rican**
☐**Other Hispanic/Latino**
☐**Decline to Answer**

Race: *Select All that Apply*
☐**American Indian/Alaska Native**
☐**Black and/or African-American**
☐**White/Caucasian**
☐**Asian:**
___Asian Indian ___Chinese ___Filipino ___Japanese
___Korean ___Vietnamese ___Other
☐**Native Hawaiian/Pacific Islander:**
___Native Hawaiian ___Guamanian or Chamorro
___Samoan ___Other Pacific Islander
☐**Decline to Answer**

Sex Assigned at Birth:
☐**Male**
☐**Female**
☐**Intersex**
☐**Decline to Answer**

Housing Status:
☐**Stable Housing**
☐**Homeless**
☐**Decline to Answer**

If homeless, select which best applies:
☐**Street**
☐**Homeless Shelter**
☐**Transitional**
☐**Doubling Up or Coach Surfing (not paying rent)**☐

How did you learn about Montgomery College Health Clinic?
☐**Friend/Patient** ☐**Website/Internet**
☐**Referral** ☐**Facebook/Social Media**
☐**Healthfair/presentation** ☐**TV/Radio/Print Media**

Do you think of yourself as:

☐**Straight or Heterosexual** ☐**Lesbian, gay or homosexual** ☐**Bisexual** ☐**Something else** ☐**Don't know**
Do you think of yourself as: ☐**Male** ☐**Female** ☐**Female –to- Male (FTM)/Transgender Male/Trans Man** ☐**Male-to-Female (MTF)/Transgender Female/Trans Woman** ☐**Genderqueer, neither exclusively male nor female** ☐**Additional Gender Category/(or Other), please specify:_____** ☐**Something else**
Income: **Anticipated annual household income for this year_____**
Emergency Contact: **Name: Relationship: Phone:**
Insurance Information: **Insurance Carrier:** **Policy Number:** **Group Number:** **Employer:** **Relationship to Insured: Insured's DOB:** **Address of Insured:**
I verify that the above information is true to the best of my knowledge information and belief. **Signature:_____** **Printed Name:_____ Date: _____**

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

1). CONSENT FOR TREATMENT:

I, _____, am voluntarily seeking medical care through the Montgomery College Health Clinic and give permission to the medical, nursing, and mental health staff to examine me, make diagnoses, and provide treatment to me accordance with the information, explanations and recommendations they provide me.

Patient Signature:_____

Printed Name:_____

Date: _____

2). CONSENT TO BILL:

_____If I do not have health insurance or health insurance which covers the charges incurred, 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 the Montgomery College Health Clinic patient financial policies;

_____If my insurance is accepted, I authorize payments to the Montgomery College Health Clinic or will reimburse Montgomery College Health Clinic if I am directly paid by my carrier;

_____I hereby authorize the Montgomery College Health Clinic to furnish information concerning my illness and treatment to my insurance carrier in accordance with its privacy policy;
I understand that my insurance may not cover all the charges deemed medically necessary by Montgomery College Health Clinic;

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

Patient Signature:_____

Printed Name:_____

Date: _____

I have received a copy of the Montgomery College Health Clinic Patient Rights and Responsibilities form. _____

MONTGOMERY COLLEGE HEALTH CLINIC ACKNOWLEDGMENT OF HIPAA NOTICE

I acknowledge that I have received a copy of the Montgomery College Health Clinic HIPAA Notice of Privacy Practices.

Patient Name (Please Print)

Patient Signature

Or

Personal Representative

Authority of Personal Representative to Sign for Patient

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

Please note: It is your right to refuse to sign this Acknowledgment

----------*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 acknowledgement;
_____A communication barrier prevented us from obtaining acknowledgement;
_____The individual was unwilling to sign
_____Other:

Staff Member (Please Print)

Signature