Family Health Centers
LONG ISLAND FQHC, INC.
10TH ANNIVERSARY
2009 - 2019
Your Health • Our Mission
Celebrating 10 years of service to Long Island Community

Patient Registration Form

Patient Information

Last Name	First Name	Middle	Home Phone	Primary Contact
			Cell Phone	☐ Home ☐ Cell ☐ Work
DOB / /	SSN#	Country Of Birth	Work Phone	
Mailing Address		Apt#	Ok to leave voice message: ☐ Yes ☐ No Ok to leave a text message: ☐ Yes ☐ No *MSG & data rates may apply	
City	State	Zip	Best time to reach you: ☐ AM ☐PM Opt out of all Practice Communication ☐	
Home Address (If Different from Mailing)			Email Address	
City	State	Zip	Preferred Language	Interpreter Needed? ☐ Yes ☐ No

Emergency Contact

Emergency Contact Full Name	Relationship
Address	Phone Number

We are requesting the following information of all patients in order to understand our patient needs better, to help our staff use the most respectful language when addressing you, and for funding purposes that may help reduce the cost of your healthcare.

Gender at Birth
☐Female ☐Male

Preferred Gender

Marital Status:
☐Single ☐Married
☐Widowed ☐Divorced
☐Separated ☐Partner

Ethnicity- Check one
☐ Hispanic
☐ Non-Hispanic
☐ Unreported/Refused

Housing Status
☐ Own – Private
☐ Rent – Private
☐ Rent – Public Housing (Section 8, NYCHA)
☐Senior Housing
☐ Homeless Shelter
☐ Street
☐ Transitional
☐ Doubling up

Gender Identity: Check as many as apply
☐Male
☐Female
☐Female-to-Male/Transgender
☐Male-to-Female/Transgender
☐Gender queer, neither exclusive male nor female
☐ Choose not to disclose

Sexual Orientation – Check one
☐Straight/ Heterosexual
☐Lesbian/Gay/Homosexual
☐Bisexual
☐Do Not Know
☐Choose Not to Disclose
☐Something else, please describe: _____

Employment Status:
☐Full Time
☐Part Time
☐Retired
☐Active Military
☐Reserved Military
☐Self Employed
☐Not Employed

Employer Name:

Student:
☐ Full Time
☐ Part Time
☐Not a Student

Race – Check as many as apply
☐ White
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ American Indian
☐ Pacific Islander
☐ Alaskan Native
☐ Other
☐ Unreported/Refused

Are you a:
Veteran ☐ Yes ☐ No
Board Member ☐ Yes ☐ No
LIFQHC employee ☐ Yes ☐ No

How did you hear about us? (Please check one)
☐ Employee
☐ Patient/Friend
☐ Newspaper
☐ Flyer/Poster/Brochure
☐ LIFQHC Event
☐ LIFQHC Website/Internet
☐ Referral
☐Insurance Company
☐Facebook/Social Media
☐Other: _____

Family Health Centers
LONG ISLAND FQHC, INC.
10TH ANNIVERSARY
2009 - 2019
Your Health • Our Mission
Celebrating 10 years of service to Long Island Community

Parent/Guardian Information – Please complete if patient is under 18 years of Age				Responsible Party
Mother's Name	DOB / /	Phone	Address	☐
Father's Name	DOB / /	Phone	Address	☐
Guardian's Name	DOB / /	Phone	Address	☐

Insurance Information:			
Primary Insurance Name		Policy #	
Name of the Insured	☐ Same as Patient	DOB of Insurance Holder / /	
Patient's Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other:		Primary Care Provider on Insurance Card	
Secondary Insurance Name:		Policy #	

Pharmacy Information		
Pharmacy Name	Phone	Address

Primary Care Provider		
PCP Name	Phone	Address
Advanced Directive: ☐ **Yes** ☐ **No** ☐ **I Decline**		**Living Will:** ☐ **Yes** ☐ **No**

Other Healthcare Providers:		
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty

I agree to allow Long Island FQHC to contact me regarding my private health information, evaluation, and treatment.

_____ _____

Signature of Patient or Representative Date

I verify that the information above is correct to the best of my knowledge.

_____ _____

Signature of Patient or Representative Date

Long Island FQHC, Inc. Consent Form

Consent to Treatment: I authorize Long Island FQHC, Inc. (LIFQHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of LIFQHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by LIFQHC personnel. HIV testing is now a part of routine care and written consent is no longer required. I do have a right to decline HIV testing at any time. The LIFQHC offers family planning services. I understand that my acceptance of family planning services is not a prerequisite to eligibility for, or receipt of, any other services that is offered by the LIFQHC.

Release of Information: I authorize LIFQHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable LIFQHC to obtain payment for the services it provides to me; and (3) to permit LIFQHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.
I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic disease

I am aware that Long Island FQHC, Inc. may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits: I assign to LIFQHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by LIFQHC

Financial Obligations: I agree, that, except as may be limited by law or LIFQHC's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at LIFQHC facilities in accordance with the rates and terms of LIFQHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

No- Show Policy – Important Notice:
Please remember to be courteous to us and other patients by calling **at least 4 hours prior** to your appointment time to cancel if you cannot make it. This will allow us to serve our patients better. Patients arriving **more than 15 minutes late** for their appointment will be counted as a no show and they will need to reschedule their appointment.

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Signature of Patient or Representative: _____ Date: _____

Nature of Relationship to Patient (if patient not signing): _____

Reports to NYS Immunization Information System: I hereby authorize LIFQHC to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

Signature of Patient or Representative: _____ Date: _____

516-296-FQHC (3742)
www.lifqhc.org

PATIENT ACKNOWLEDGEMENT
OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have been provided a copy of the Long Island FQHC, Inc. (LIFQHC) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by LIFQHC and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient or Representative: _____ Date _____

Name of Personal Representative:_____
(Printed) (If Applicable)

Relationship to Patient:_____
(If Applicable)

RHIO CONSENT FORM
Long Island Federally Qualified Health Centers
"LIFQHC"

In this Consent Form, you can choose whether to allow LIFQHC to obtain access to your medical records through a computer network operated by HEALTHIX which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow LIFQHC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, LIFQHC's staff involved in my care may see and get access to all of my medical records through HEALTHIX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, LIFQHC may not be given access to my medical records through HEALTHIX for any purpose."

RHIOs is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask LIFQHC for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ☐ **I GIVE CONSENT for LIFQHC to access ALL of** my electronic health information through HEALTHIX in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for LIFQHC to access** my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.

  NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHIX.

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

Family Health Centers
LONG ISLAND FQHC, INC.
• Your Health • Our Mission •
NuHealth

RHIO Consent Process

Details about patient information in HEALTHIX and the consent process:

1. How Your Information will be used. Your electronic health information will be used by LIFQHC only to:

   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of information about You Are Included. If you give consent, LIFQHC may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from *[Provider Organization OR RHIO, as applicable]*. You can obtain an updated list of information Sources at any time by checking the HEALTHIX's website.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: doctors and other health care providers who serve on [Name of Provider Organization']s medical staff who are involved in your medical care; health care providers who are covering or on call for LIFQHC's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call LIFQHC at: 516.571.8600; or visit HEALTHIX's website: www.healthix.org; or call the NYS Department of Health at 877-690-2211.

6. Re-disclosure of information. Any electronic health information about you may be re-disclosed by LIFQHC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HEALTHIX and persons who access this information through the HEALTHIX must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to *[Provider Organization or RHIO, as applicable]*. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on HEALTHIX's website at www.healthix.org, or by calling 877-695-4749. Note: Organizations that access your health information through HEALTHIX while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it.

Eligibility Determination for Sliding Fee Discounts

It is Long Island FQHC, Inc. (LIFQHC) policy to provide essential services to all patients regardless of the patient's ability to pay. Discounts are set by the LIFQHC consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at LIFQHC, but not for those services provided outside the Health Center.

Please complete the following information, even if you have insurance.

Household Income Before Taxes

HOUSEHOLD MEMBER	NUMBER	MONTHLY INCOME	YEARLY INCOME
Self Name:			
Spouse			
Dependent Children			
Other dependents			
Total			

☐ I am declining to provide information on my income and family size and agree to pay the full LIFQHC fee.

ACCEPTABLE PROOF OF INCOME IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP LIFQHC INFORMED.

☐ I certify that all information shown above is true, accurate and correct. I understand that if LIFQHC determines that I misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts provided.

☐ I agree to provide documentation of my income at my next visit.

Name (print)_____ Signature: _____

Witness:_____ Date: _____

Staff to complete information below

1. Eligible for Sliding Fee Discount: Yes ___ No _____ Patient Refused _____
2. If yes, acceptable proof of income provided: Yes ___ No _____ Patient Refused _____
3. If insured, Health insurance card provided: Yes ___ No _____ Not applicable _____
4. Patient reports no income Yes ___
5. Patient is unable to obtain proof from an employer (This includes paid in cash/off the books earnings) Yes ___

If yes, to either question 4 or 5, please fill out the attached Self-Attestation Form

Family Planning Sliding Scale Code (SS1- SS5 or N/A) _____