

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.

Medical Record #
(For office use only)

Client Registration

Legal Name Last First Middle Initial	Preferred name
Legal Sex (please check one)* <input type="checkbox"/> Female <input type="checkbox"/> Male <i>*While Fenway recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal 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.</i>	Date of Birth Month Day Year / /
Do you identify as Transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #
<i>Preferred pronouns:</i> _____	State ID # or License #

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone () -	Cell Phone () -	Work Phone () -	Best number to use: <input type="radio"/> Home <input type="radio"/> Cell <input type="radio"/> Work
Local Address	City	State	ZIP
Billing Address (if different from above)	City	State	ZIP
Email address:			
Occupation	Employer/School Name	Are you covered under school or employer's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact's Name	Phone Number	Relationship to you	
<i>If you are under 19, the Department of Public Health requires that you provide parent/guardian contact information.</i>			
Parent/Guardian Name	Phone Number	Relationship to you	
May Fenway Health send mail to your local address (check one)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>This question only refers to mail for purposes other than billing. Payment is expected at the time of your visit.</i>			

This information is for demographic purposes only and will not affect your care.

1.) Which of the categories best describes your current annual income? Please check the correct category: <input type="checkbox"/> < \$10,000 <input type="checkbox"/> \$10,000 - 14,999 <input type="checkbox"/> \$15,000 - 19,999 <input type="checkbox"/> \$20,000 - 29,999 <input type="checkbox"/> \$30,000 - 49,999 <input type="checkbox"/> \$50,000 - 79,999 <input type="checkbox"/> Over \$80,000	2.) Employment Status <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	3.) Racial Group(s) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi racial <input type="checkbox"/> Native American / Alaskan Native / Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	4.) Ethnicity <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino/Latina 5) Country of Birth <input type="checkbox"/> USA <input type="checkbox"/> Other _____
6.) Language(s) <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Français <input type="checkbox"/> Português <input type="checkbox"/> Русский Other _____	7.) Do you think of yourself as: <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know	8.) Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____ 9.) Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran	10.) Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Friend or Family Member <input type="checkbox"/> Health Provider <input type="checkbox"/> Emergency Room <input type="checkbox"/> Ad/Internet/MediaOutreach WorkerSchool <input type="checkbox"/> Other _____

I certify that the above information is true and correct.

Please turn over

Patient Signature: _____ **Date:** _____



Fenway Health – Consent for Treatment

Patient Name: _____ Date: _____

Time: _____ (A.M./P.M.)

I hereby give my consent and authorize Fenway Health 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 authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- 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 Fenway Health 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 have received a copy of Fenway'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, mental 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 patients 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.