FENWAY HEALTH

Client Registration

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)

Legal Name* Last First Middle Initial **Preferred name:**

Legal Sex (please check one)* ☐ Female ☐ Male
**While Fenway 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.*

Preferred pronouns:

Date of Birth *Month Day Year*
/ /

Social Security #

State ID # or License #

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:
☐ Home ☐Cell ☐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?
☐ Yes ☐ No

Emergency Contact's Name Phone Number Relationship to you

If you are under 19, the Department of Public Health requires that you provide parent/guardian contact information.
Parent/Guardian Name Phone Number Relationship to you

***Fenway Health will send certain correspondence, such as bills, to your mailing address*. How would you prefer to receive other types of written correspondence? (check one)** ☐ Secure Email (MyFenway) ☐ Letter ☐ Other

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

1.) What is your annual income?
_____
❑ No income

1a.) 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 / Inuit
❑ Pacific Islander
❑ Other _____

4.) Ethnicity
❑ Hispanic/Latino/Latina
❑ Not Hispanic/Latino/Latina

5) Country of Birth
❑ USA
❑ Other _____

6.) Preferred Language (choose one:)
❑ English
❑ Español
❑ Français
❑ Português
❑ Русский
Other _____

7.) Do you think of yourself as:
❑ Lesbian, gay, or homosexual
❑ Straight or heterosexual
❑ Bisexual
❑ Something else
❑ Don't know

8.) Marital Status
❑ Married
❑ Partnered
❑ Single
❑ Divorced
❑ Other_____

9.) Veteran Status
❑ Veteran
❑ Not a Veteran

10.) Referral Source
❑ Self
❑ Friend or Family Member
❑ Health Provider
❑ Emergency Room
❑ Ad/Internet/MediaOutreach WorkerSchool
❑ Other _____

11.) What is your gender?
☐ Female
☐ Male
☐ Genderqueer or not exclusively male or female

12.) What was your sex at birth?
☐ Female
☐ Male

13.) Do you identify as transgender or transsexual?
☐ Yes
☐ No
☐ Don't know

Please turn over

FENWAY HEALTH

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 understand that Fenway Health 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.

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 certify that the above information is true and correct. 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.