CIFC Health (please print clearly)

Patient Information

Last Name | First Name | Middle Initial | Date of Birth: month/day/year

Street Address: | Unit # | City | State | Zip Code

Phone 1: Primary Contact? ☐ | Phone 2: Primary Contact? ☐ | Phone 3: Primary Contact? ☐

Phone 1 is OK for CONFIDENTIAL messages: ☐YES ☐NO | Phone 2 is OK for CONFIDENTIAL messages: ☐YES ☐NO | Phone 3 is OK for CONFIDENTIAL messages: ☐YES ☐NO

How do you want to receive reminders and notifications? ☐ Text ☐ Voice Message (if voice message, select: ☐Home ☐Cell ☐Work)

Contact

Emergency Contact 1:
Name: | Relation: | Phone 1: ☐Celll ☐Home ☐Work | Phone 2: ☐Celll ☐Home ☐Work

To Medical Contact 1, CIFC Health can:
1) Disclose your medical information? ☐YES ☐NO
2) Leave a detailed message with them? ☐YES ☐NO
3) Contact this person in an emergency? ☐YES ☐NO

Emergency Contact 2:
Name: | Relation: | Phone 1: ☐Celll ☐Home ☐Work | Phone 2: ☐Celll ☐Home ☐Work

To Medical Contact 2, CIFC Health can:
1) Disclose your medical information? ☐YES ☐NO
2) Leave a detailed message with them? ☐YES ☐NO
3) Contact this person in an emergency? ☐YES ☐NO

Do you have health insurance? ☐ YES ☐ NO

Can we help you apply for?
☐ Husky/Medicaid ☐ Health Insurance - Access Health CT
☐ Financial Assistance - Our in-house sliding-fee scale program

Which pharmacy do you use?

Who is your primary care provider (PCP)?

Insurance

Primary Insurance: Company Name | ID# | Group #

Policyholder info: *Check here if patient is the primary:* ☐ *If someone else, fill out below*

Last Name | First Name | Date of Birth (month/day/year) | Relationship to patient

Street Address (Check here if address is same as patient ☐) | Apt/Floor | Town | State | Zip Code

Secondary Insurance: Company Name | ID# | Group #

Policyholder info: *Check here if patient is the primary:* ☐ *If someone else, fill out below*

Last Name | First Name | Date of Birth (month/day/year) | Relationship to patient

Street Address (Check here if address is same as patient ☐) | Apt/Floor | Town | State | Zip Code

*Required Information

Sex assigned at birth:
☐Male
☐Female

Marital Status:
☐Single
☐Seperated
☐Divorced
☐Married
☐Together
☐Widowed

Are you Homeless?
☐YES (Select below) ☐NO (Skip below)
- ☐Doubling-up (living with another family)
- ☐Street
- ☐Homeless Shelter (temporary/overnight stay)
- ☐Transitional (Longer temporary housing)
- ☐Other: _____

Language Preference:
☐English ☐Portuguese
☐Spanish ☐Other:_____

Employement Status:
☐Retired
☐Employed- Full time
☐Employed- Part time
☐Self-Employed
☐Unemployed
☐Student-Full Time
☐Student-Part Time

Ethnicity
select all that apply
Hispanic/Latino:
☐Yes, from which country?_____
☐No ☐Decline to answer

Race
select all that apply
☐Asian: from which country?_____
☐Native Hawaiian
☐Other Pacitic Islander
☐Guamanian or Chamorro
☐Samoan
☐Black/ African American
☐Native American/ Alaskan
☐White
☐Decline to answer

Other questions: (required)

Do you want a translator:
☐YES
☐NO

Are you a Veteran?
☐YES
☐NO

Access

E-mail:

This email grants you access to your health information, including appointments & visit notes. You can use your secure account in a web browser or our encrypted mobile app.

If you DO NOT WANT TO BE ABLE access to your health information this way, you can DECLINE YOUR ACCESS by checking this box: ☐

Income

CIFC Health receives Federal Grants which require us to ask for this information.

How many people are in your household?_____ Household Income: $_____

☐Weekly: How many weeks do you work each year? _____
☐Monthly: How many months do you work each year? _____
☐Annually

Signature of Patient/Guardian: _____ **Date:** _____

Financial Agreement & Assignment of benefits:

- I authorize the submission of a claim for Payment to Medicare, Medicaid or any other payer for any services provided to me or my children under 18 years of age as listed on the demographic sheet, now, in the past or in the future.
- I understand and agree that I am ultimately responsible for the balance for myself and all my identified children under 18 years of age as listed on the demographic sheet for any professional services rendered and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.
- I authorize payment of my medical benefits to be sent directly to CIFC Health or it's individual providers for services rendered for me and all my identified children under 18 years of age as listed on the demographic sheet. Should my insurance claim be denied for lack of eligibility or termination of coverage, I understand that I will be held responsible and intend to make payment for any balance due in those instances.
- I authorize CIFC Health to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to CIFC Health and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by CIFC Health, in the past, now or in the future.

Person Responsible for Payment: ☐ Patient ☐ Parent/Guardian ☐ Spouse ☐ Other:

Last name	First name	M.I.	Phone	Date of Birth: (month/day/year)

Street Address (Check here if address is same as patient ☐) | Apt/ Floor | Town | State | Zip Code

Signature of Patient/Guardian: _____ **Date:** _____

Authorization to Treat

- I hereby give permission to the staff of the CIFC Health Center to provide medical, dental, and behavioral health treatment, and vaccine administration.
- For emergency situations when I cannot be reached, I give permission for my minor dependents to be treated for the emergency conditions.

Signature of Patient/Guardian: _____ **Date:** _____

Health Records

I hereby authorize CIFC Health to obtain my health information, including utilizing electronic health information exchange entities (HIEs), whereby my health information may be received from and/or shared with external healthcare service professionals electronically for the purpose of my healthcare.

Signature of Patient/Guardian: _____ **Date:** _____

If you DO NOT wish to participate with Commonwell/Carequality you can DECLINE by checking this box: ☐

CIFC Health may obtain my medical records:

☐ **Yes**- Authorization form attached.
☐ **NO** - I do not wish to release past and present medical information to CIFC Health.
NOTE: Missing medical record information, as well as the patient's health history, increases the risk of complications during treatment.

CIFC Health Office Use Only: (Card Copies for relevant Patient/Authorized Rep/Guardian)

1. Photo ID was:	2. Insurance Card was:	3. Documents Given	4. Financial Assistance Eligibility
☐ Copied/Scanned	☐ Copied/Scanned	☐ Welcome Letter/PCMH Packet	☐ Has current card: ___/___/___ (expiration date)
☐ On File & CONFIRMED	☐ On File & CONFIRMED	☐ ROI Update	☐ Has appointment: ___/___/___
	☐ Not with Patient Today		☐ Not currently eligible

5. Data Consent: ☐ Opt in/out was identified ☐ Response was documented in eCW

CIFC Health staff recipient's name:	staff signature:	date received & signed:
_____	_____	_____/_____/_____