DEPAUL COMMUNITY HEALTH CENTERS

REGISTRATION FORM

(Please Print)

Today's Date:	Provider:

PATIENT INFORMATION

Last Name:	First Name:	MI:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Preferred Pharmacy:

Social Security #:	Birth Date:	Marital Status:
	/ /	❑ Single ❑ Divorced ❑ Partnered ❑ Married ❑ Separated ❑ Widowed

Street Address or P.O. Box:	City:	State:	ZIP Code:

Email Address:	Home Phone No.:	Cell Phone No.:
	( )	( )

Occupation:	Employer:	Employer Phone No.:
		( )

During the past year, what was the total combined income for you and the family members you live with?	How many family members, including yourself, do you currently live with?
$	

Preferred Contact Instructions:	What language are you most comfortable speaking?	Do you have an Advanced Directive?
❑ Phone ❑ Text ❑ Email ❑ Do not contact ❑ Mail ❑ Other: _____	❑ English ❑ Spanish ❑ Arabic ❑ Portuguese ❑ Other:_____	❑ Yes (please provide a copy for your medical record) ❑ No

Race:		Hispanic, Latino or Spanish Origin?	Highest level of school:
❑ Black or African-American ❑ White ❑ American Indian or Alaska Native ❑ Native Hawaiian ❑ Samoan ❑ Guamanian or Chamorro ❑ Other Pacific Islander: _____	❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Asian:	❑ No, not Hispanic or Latino/a. ❑ Yes, Mexican, Mexican Am., Chicano/a. ❑ Yes, Puerto Rican. ❑ Yes, Cuban. ❑ Yes, another Hispanic or Latino origin:	❑ Elementary ❑ Some high school ❑ High school diploma or GED ❑ Some college or technical school ❑ Bachelor's degree ❑ Any post graduate studies

Do you consider yourself to be:	Gender Identity:	Sex Assigned at Birth:	Preferred Gender Pronoun:
❑ Straight or heterosexual ❑ Lesbian, gay or homosexual ❑ Bisexual ❑ Don't know ❑ Something else:_____	❑ Male ❑ Female ❑ Transgender Female (Male to Female) ❑ Transgender Male (Female to Male) ❑ Do not identify as male, female or transgender	❑ Male ❑ Female	❑ He/him ❑ She/her ❑ They/them

Veteran Status:	Housing Status:		Agricultural / Migrant Worker?	
❑ Veteran ❑ Non-Veteran	❑ Stable/permanent ❑ Transitional	❑ Doubling up ❑ Homeless	❑ Yes	❑ No

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How hard it is it for you to pay for the very basics (food, housing, medical care)?	Was there a time in the past 12 months when you did not take your medications as prescribed because of cost?
❑ Very hard ❑ Somewhat hard ❑ Not hard at all	❑ Yes ❑ No
How do you *usually* get to medical appointments? ❑ Drive myself ❑ Get a ride from family or friends ❑ Take bus or street car ❑ Walk ❑ Bicycle ❑ Ride in service agency van ❑ Taxi ❑ Other: _____ **Are you a registered voter?** ❑ Yes ❑ No	**Referred to clinic by (please check one box):** ❑ Friend ❑ Family ❑ Doctor: _____ ❑ Close to home/work ❑ Hospital: _____ ❑ Yellow Pages ❑ Insurance Plan ❑ Web Search ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:			Policy Number:	Group Number:
Subscriber's Last Name:	**First Name:**	**MI:**	**Subscriber's S.S. #:**	**Subscriber's Date of Birth:**
				/ /
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other			**Co-payment: $**
Secondary Insurance:			**Policy Number:**	**Group Number:**
Subscriber's Last Name:	**First Name:**	**MI:**	**Subscriber's S.S. #:**	**Subscriber's Date of Birth:**
				/ /
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other			**Co-payment: $**

EMERGENCY CONTACT INFORMATION

Name of local friend or relative (not living at same address):	Relationship to patient:
Home Phone No.:	**Work Phone No.:**

☐ **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DePaul Community Health Centers or the insurance company to release any information required to process my claims. This authorization shall remain valid until I, revoking said authorization, give written notice.**

☐ **I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of DePaul Community Health Centers.**

☐ **I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.**

Patient / Guardian Name (Print):	
Patient / Guardian Signature:	***Date:***
Relationship to Patient:	

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HOUSEHOLD ASSESSMENT

Please list income for all household members. This does not include guests, roommates, or non-dependent family members.

Source	Amount	Weekly	Biweekly	Monthly	Annually
Salaries and Wages (Self)	$	☐	☐	☐	☐
Salaries and Wages (Spouse)	$	☐	☐	☐	☐
Workman's Comp	$	☐	☐	☐	☐
Social Security	$	☐	☐	☐	☐
SSI (Supplemental Security)	$	☐	☐	☐	☐
Child Support/Alimony	$	☐	☐	☐	☐
Tip Income	$	☐	☐	☐	☐
Military/Veterans Benefits	$	☐	☐	☐	☐
Public Assistance/Food Stamps	$	☐	☐	☐	☐
Stocks/CDs/Savings	$	☐	☐	☐	☐
Interest Income	$	☐	☐	☐	☐

Please list all dependent family members by NAME, DATE OF BIRTH and SOCIAL SECURITY NUMBER. Please be sure to include yourself.

Name	Date of Birth	Social Security Number *(if known)*

DePaul Community Health Centers reserves the right to inspect your tax return and/or wage statement for previous periods upon request. Eligibility will be updated on an annual basis. Please notify us immediately if there are any changes in your income status prior to your annual update.

☐ I hereby certify that the income and family composition information supplied above is true and correct to the best of my knowledge. I understand that the document will be maintained in my permanent file and that falsification of any of the information above may constitute a federal offense.

☐ I refuse to complete this assessment. I understand that my refusal to take this assessment will make me ineligible for the sliding fee scale discount.

Patient Signature Date

Printed Patient Name

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PERMISSION TO RELAY INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you. ***Some method of contact must be provided***.

DePaul Community Health Centers will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

DePaul Community Health Centers also utilizes 3rd party entities to disclose certain PHI, including 3rd party medical record coordination, health information exchanges (HIE) with local hospitals and medical providers, and the patient portal.

This request supersedes any prior request for communication of information submitted prior to the date below.

EXTENDED AUTHORIZATION

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name (First and Last)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

RESTRICTIONS ON COMMUNICATION METHODS

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do **NOT** want to receive communications:

□ No calls to phone number(s): _____
□ No messages or voice mails left on phone number(s):
□ No mail to the following address: _____
□ 3rd Party Medical Record Coordination
□ Health Information Exchange (HIE)
□ Patient Portal
□ Other (please specify): _____

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: October 9, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to DePaul Community Health Centers, its affiliates and its employees. DePaul Community Health Centers will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by DePaul Community Health Centers. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- □ Any purpose required by law;
- □ Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- □ If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- □ To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- □ To your employer when we have provided health care to you at the request of your employer;
- □ To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- □ Court or administrative ordered subpoena or discovery request;

- □ To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- □ To coroners and/or funeral directors consistent with law;
- □ If necessary to arrange an organ or tissue donation from you or a transplant for you;
- □ If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- □ To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- □ Public health activities;
- □ Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- □ Treatment and payment purposes;
- □ Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- □ Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- □ Providing you with a copy of your health information or an accounting of disclosures;
- □ Disclosures required by law;

- □ Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- □ Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid DePaul Community Health Centers in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights Department of HHS:
Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278
Voice Phone (212) 264-3313
FAX (212) 264-3039
TDD (212) 264-2355

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the DePaul Community Health Centers Privacy Officer, Julie Firstley, by phone at (504) 482-2080 or at the following address: P.O. Box 4148, New Orleans, Louisiana 70118. This Notice of Privacy Practices is also available on our DePaul Community Health Centers web page at www.dchcno.org.