FENWAY HEALTH

Medical Record #
(For office use only)

Returning Patient Information

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.

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 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.*			**Social Security #**

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:** □ 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	
May Fenway Health send mail to your local address (check one)? ☐ Yes ☐ No *This question only refers to mail for purposes other than billing. Payment is expected at the time of your visit.*			

This demographic information is for funding purposes. Your responses will not affect your care.

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

Please turn over

FENWAY HEALTH

FINANCIAL GUARANTOR INFORMATION

Please print and fill in all areas.

Your Insurance			**Phone No. for Eligibility/Verification** ( ) -
ID/Policy #	**Group #**		
Policy Effective Date	**Co-Payment**		**Co-Insurance or Deductible**
Employer/School Name	Address	City	State Zip
If you are covered under someone else's insurance policy, please complete the following:			
Primary Subscriber's Name	**Primary Subscriber's SS#**		**Relationship to You**
Primary Subscriber's Employer	**Primary Subscriber's Employer's Address**		**Primary Subscriber's Phone No.** ( ) -
Primary Subscriber's Policy #	**Primary Subscriber's Group #**		

Authorization and Assignment of Insurance Benefits/Release of Medical Information: I authorize and request my insurance company or companies to pay benefits to Fenway Community Health ("Fenway") for services rendered. I authorize the release of any medical records and/or other information required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including, if applicable, my employer, employer's workman's compensation insurance company, the Social Security Administration and/or the Centers for Medicare & Medicaid Services, needed to determine benefits and to process insurance claims and secure payments of benefits to either the insured or to Fenway. Additionally, I will submit fully completed claim forms as requested by my insurer or Fenway.

Referrals and Authorizations: If I have an insurance plan that requires any referrals, pre-certifications and/or authorizations, I understand that it is my responsibility and not Fenway's to obtain approval from my insurer for medical services prior to such services being rendered by notifying my PCP of my request and providing all required documentation. If any medical services are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible, and that any of these aforementioned actions do not guarantee that my insurer will pay for the claims. Any denial of claims is between the policy holder and my insurer. I understand medical services may not be rendered without the proper referral on file.

Financial Agreement: I agree that payment in full is due at the time of treatment. I understand that I may be billed separately for services rendered by other professionals in the building including, but not limited to, laboratory services. I understand that if a referral is not obtained from my insurer or if my insurer refuses to cover any or all charges for services provided, that I am responsible for and agree to pay any and all charges denied by my insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the policyholder and the insurer. Any assistance in this matter granted by Fenway is given strictly as a courtesy and implies no responsibility on Fenway's part for filing, follow through or confirmation. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fee(s) for service(s). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependant to insurance plan, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of services rendered. I understand Fenway reserves the right to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify credit bureaus of my delinquencies.

Certification: I certify that the information I provided above is true and complete. I agree to inform Fenway immediately of any change in insurance coverage, benefits and/or change of personal information. I permit a copy of this authorization and signature to be used in place of this original on all insurance claim and submissions, whether manual, electronic or telephonic. I understand and agree that the terms herein are reaffirmed each time services are rendered.

I certify that the above information is true and correct.

Patient Signature: _____ **Print Name:** _____ _____ **Date:** _____