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)

The questions below are about your insurance*. If you do not have insurance, list what is on your legal ID.

*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 listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If you use a name and/or pronouns different from these, please let us know below, as indicated. If you are unsure what to list, ask a member of Patient Services for clarification.

Last Name	**First Name**	**Middle Initial**
Date of Birth (mm/dd/yyyy)	**Social Security #**	**Sex Marker** ☐M ☐F

How would you like our staff to refer to you?

First Name	**Pronouns**

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

Cell Phone ( ) Ok to leave voicemail? ☐ yes ☐ no	**Home Phone** ( ) Ok to leave voicemail? ☐ yes ☐ no	**Work Phone** ( ) Ok to leave voicemail? ☐ yes ☐ no	**Best number to use** ☐ cell ☐ home ☐ work
Address	city	state	zip
Email Address			
Occupation	Name of employer/school	Are you covered under school/employer's insurance? ☐ yes ☐ no	
Emergency Contact's name	Phone #	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			

Please turn over

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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/Latinx
☐ Not Hispanic/Latino/ Latina Latinx

5. Country of Birth

☐ USA
☐ Other:

_____

6. Preferred Language
(choose one)

☐ English
☐ Español
☐ Français
☐ Português
☐ Русский
☐ Other:

_____

7. Sexual Orientation

☐ Lesbian
☐ Gay
☐ Straight or heterosexual
☐ Bisexual
☐ Another orientation:

_____

☐ Don't know/not sure

8. Marital Status

☐ Married
☐ Partnered
☐ Single
☐ Divorced
☐ Other _____
☐ Don't know/not sure

9. Veteran Status

☐ Veteran
☐ Not a Veteran

10. Referral Source

☐ Self
☐ Friend or Family Member
☐ Health Provider
☐ Emergency Room
☐ Ad/Internet/Media/ Outreach Worker/School
☐ Other:

_____

11. How would you best describe your gender?

☐ Female/Woman
☐ Male/Man
☐ Trans woman or Transfeminine
☐ Trans man or Transmasculine
☐ Nonbinary, genderqueer, or not exclusively male or female
☐ Another gender:

_____

12. What sex* was listed on your first birth certificate?

*We are currently testing the best ways for us to capture additional sexes. We know this question does not currently fully represent our communities.

☐ Female
☐ Male

13. Do you identify as trans, transgender, transsexual, or as having a trans history?

☐ Yes
☐ No
☐ Don't know / Not sure

FENWAY HEALTH

Consent for Treatment

Medical Record #
(For office use only)

Patient Name ▲ Date Time (am/pm)

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, including a sliding scale fee program.
- 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 consent to Fenway Health sending me one or more messages per day related to my health care. I understand data usage costs may apply based on my mobile carrier plan.
- 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's name used, if different from chart

Patient Signature ▲ Date

Legally authorized representative Relationship to Patient Date

General Information: Informed consent will be obtained from all patients accessing medical, behavioral 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.