FENWAY HEALTH

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)*

Patient Registration- Minor

Child's Legal Name* Last	First	Middle Initial	**Child's Name used:**

Child's 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.*

Child's Pronouns used:

Child's Date of Birth *Month Day Year* / /	**Child's Social Security #**	**Child's State ID # or License #** (if applicable)

For patients under 18, the Department of Public Health requires that we obtain parent/guardian contact information:

Parent/Guardian Name	Date of Birth	Relationship to child	Phone Number
Other Parent/Guardian Name	Date of Birth	Relationship to child	Phone Number

Parent/Guardian Occupation	Employer/School Name	Is child covered under school or employer insurance? ☐ Yes ☐ No

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

Home Phone	**Cell Phone** (check whose phone)	**Work Phone** (check whose phone)	**Best number to use:**
( )	☐ Child ☐ Parent/Guardian	☐ Child ☐ Parent/Guardian	☐ Home ☐ Cell
Ok to leave voicemail? ☐ Yes ☐ No	( )	( )	☐ Work
	Ok to leave voicemail? ☐ Yes ☐ No	**Ok to leave voicemail?** ☐ Yes ☐ No	

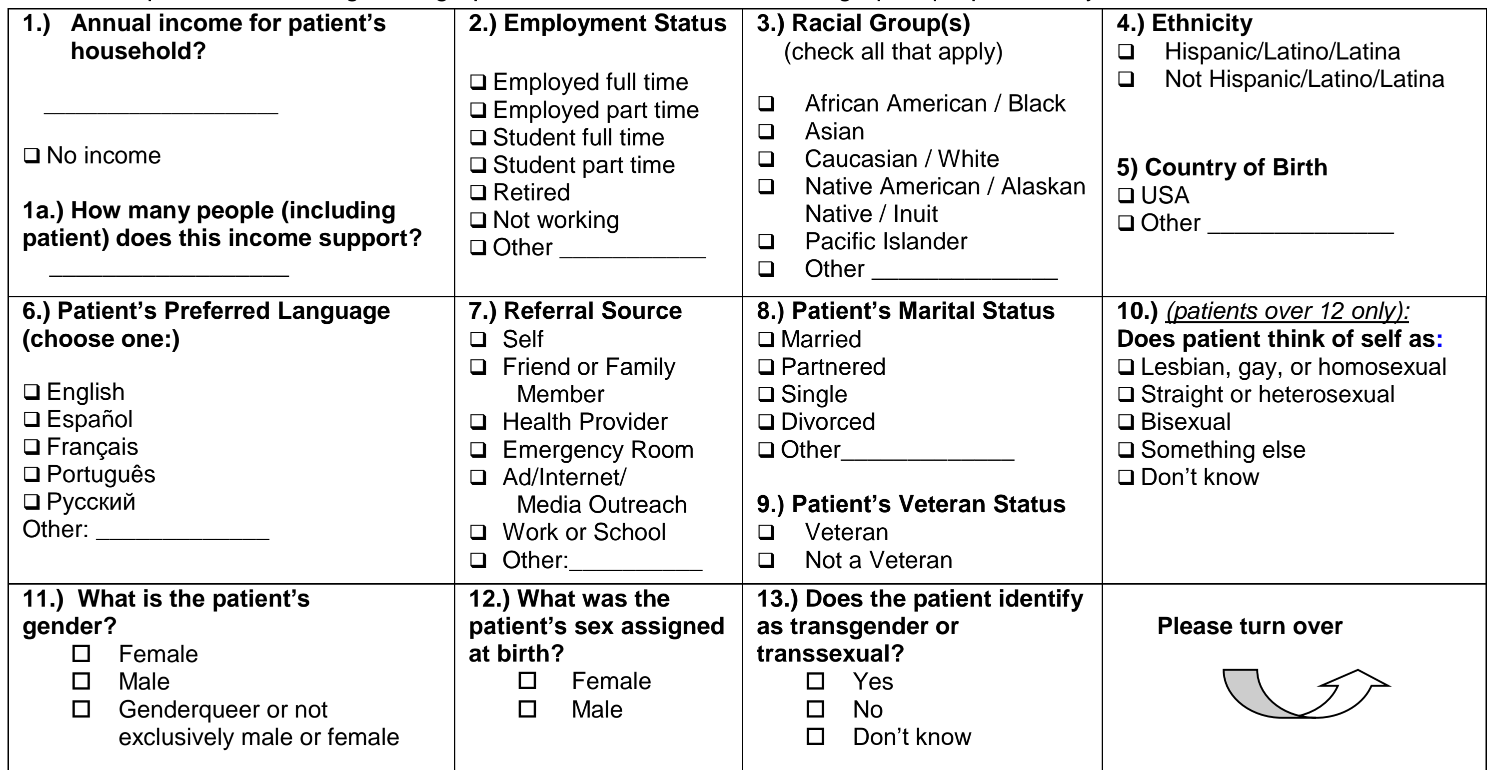
Address	City	State	ZIP

For Patients aged 12 and older: Patient's own Email address: ______________________________

For Patients below the age of 12: Parent/Guardian Email address: ______________________________

***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 complete the following demographic information. It is for demographic purposes only and will not affect care.



1.) Annual income for patient's household? ______________ ❑ No income **1a.) How many people (including patient) does this income support?** ______________	**2.) Employment Status** ❑ Employed full time ❑ Employed part time ❑ Student full time ❑ Student part time ❑ Retired ❑ Not working ❑ 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.) Patient's Preferred Language (choose one:) ❑ English ❑ Español ❑ Français ❑ Português ❑ Русский Other: ____________	**7.) Referral Source** ❑ Self ❑ Friend or Family Member ❑ Health Provider ❑ Emergency Room ❑ Ad/Internet/ Media Outreach ❑ Work or School ❑ Other:__________	**8.) Patient's Marital Status** ❑ Married ❑ Partnered ❑ Single ❑ Divorced ❑ Other____________ **9.) Patient's Veteran Status** ❑ Veteran ❑ Not a Veteran	**10.)** *(patients over 12 only):* **Does patient think of self as:** ❑ Lesbian, gay, or homosexual ❑ Straight or heterosexual ❑ Bisexual ❑ Something else ❑ Don't know
11.) What is the patient's gender? ☐ Female ☐ Male ☐ Genderqueer or not exclusively male or female	**12.) What was the patient's sex assigned at birth?** ☐ Female ☐ Male	**13.) Does the patient identify as transgender or transsexual?** ☐ Yes ☐ No ☐ Don't know	**Please turn over**

FENWAY HEALTH

Fenway Health – Parent/Guardian Consent for Treatment of Minor

Patient Name: ____________________________ Date: ______________Time: ______________ (A.M./P.M.)

I, _______________________(print Parent/Guardian name here) am the parent/guardian of _________________(print Patient name here), currently a minor whose date of birth is ____/____/_____.
(mm / dd / yyyy)

I authorize Fenway Health to provide medical and/or behavioral health care to my child including, but not limited to, diagnostic examinations (including radiology and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary medical treatment and behavioral health counseling. For surgical procedures, or more extensive medical care, attempts will be made to contact me before such care is initiated.

I understand that care may be provided without my consent when, in the opinion of the clinician, a delay in treatment would endanger the life, limb, or behavioral wellbeing of the patient. I also understand that if an injury/illness is determined to be life threatening that an ambulance will be called to take my child to the hospital and that the clinician will make every effort to contact me.

I understand that Fenway Health routinely performs confidential testing on adolescent patients as recommended by the American Academy of Pediatrics and the Centers for Disease Control. I understand that under Massachusetts Law, Fenway Health cannot discuss the results of these tests with a parent or guardian, even though such tests may appear on insurance or billing documents. I further understand that once my child reaches the age of maturity, my consent for treatment is no longer required and this consent form is no longer valid.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical or behavioral 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 acknowledge that I have read and understand this consent, and that any questions I had prior to signing could be answered by contacting Fenway Health Patient Services. 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.

Parent/Guardian Signature: _______________________ 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.

The patient and/or family, as appropriate, are given information about:

- The patient's 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.