

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)


Client Registration

Legal Name* Last		First	Middle Initial	Name used:
Legal Sex (please check one)* <input type="checkbox"/> Female <input type="checkbox"/> Male <small>*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.</small>				Pronouns:
Date of Birth	Month / Day / Year	Social Security #	State ID # or License # (if applicable)	

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

Home Phone () Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone () Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone () Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Best number to use: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Address		City	State	ZIP
Email address:				
Occupation	Employer/School Name	Are you covered under school or employer's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact's Name	Phone Number	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) <input type="checkbox"/> Secure Email (MyFenway) <input type="checkbox"/> Letter <input type="checkbox"/> Other				

This information is for demographic purposes only and will not affect your care.

1.) What is your annual income? _____ <input type="checkbox"/> No income 1a.) How many people (including you) does your income support? _____	2.) Employment Status <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____	3.) Racial Group(s) (check all that apply) <input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Native American / Alaskan Native / Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	4.) Ethnicity <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Not Hispanic/Latino/Latina 5) Country of Birth <input type="checkbox"/> USA <input type="checkbox"/> Other _____
6.) Preferred Language (choose one): <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Français <input type="checkbox"/> Português <input type="checkbox"/> Русский Other _____	7.) Do you think of yourself as: <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know	8.) Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____ 9.) Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran	10.) Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Friend or Family Member <input type="checkbox"/> Health Provider <input type="checkbox"/> Emergency Room <input type="checkbox"/> Ad/Internet/Media Outreach <input type="checkbox"/> Work or School <input type="checkbox"/> Other _____
11.) What is your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or not exclusively male or female	12.) What was your sex assigned at birth? <input type="checkbox"/> Female <input type="checkbox"/> Male	13.) Do you identify as transgender or transsexual? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Please turn over 

Fenway Health – Consent for Treatment

Patient Name: _____ Date: _____

Time: _____ (A.M./P.M.)

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 Signature: _____ Date: _____

Legally authorized representative: _____ Date: _____

Relationship to Patient: _____

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.