CIFC Health (please print clearly)

Patient Contact Info

Last Name	First Name	Middle Initial	Date of Birth: month/ day / year

Street Address	Unit #	Town	State	ZIP code

Phone 1 (home): Primary Contact? ☐	Phone 2 (cell): Primary Contact? ☐	Phone 3 (work): Primary Contact? ☐
Phone 1 is OK for CONFIDENTIAL messages: ☐ **Yes** ☐ **No**	Phone 2 is OK for CONFIDENTIAL messages: ☐ **Yes** ☐ **No**	Phone 3 is OK for CONFIDENTIAL messages: ☐ **Yes** ☐ **No**

How do you want to receive reminders and notifications? ☐ Text ☐ Voice message (if voice message select: ☐ Home ☐ Cell ☐ Work)

Contacts

Emergency Contact 1:
Name:

Relation:

Phone 1: ☐ Cell ☐ Home ☐ Work

To Emergency Contact 1, CIFC Health can:
(1) leave a detailed message with them? ☐ **YES** ☐ **NO**
(2) release or disclose your medical information? ☐ **YES** ☐ **NO**
(3) contact this person in an emergency? ☐ **YES** ☐ **NO**

Phone 2: ☐ Cell ☐ Home ☐ Work

Emergency Contact 2:
Name:

Relation:

Phone 1: ☐ Cell ☐ Home ☐ Work

To Emergency Contact 2, CIFC Health can:
(1) leave a detailed message with them? ☐ **YES** ☐ **NO**
(2) release or disclose your medical information? ☐ **YES** ☐ **NO**
(3) contact this person in an emergency? ☐ **YES** ☐ **NO**

Phone 2: ☐ Cell ☐ Home ☐ Work

Do you have health insurance? ☐ **YES** ☐ **NO**

Can we help you apply for? :
☐ **Husky/Medicaid** ☐ **Health Insurance** – Access Health CT
☐ **Financial Assistance** – Our in-house Sliding-Fee Scale Program

Which pharmacy do you use?

Who is your Primary Care Provider?

Insurance

Primary Insurance:	Company Name	ID #	Group #

Policyholder Info:

Last Name	First Name	Date of Birth (month/day/year)	Relationship to Patient

Street Address	Apt/Floor	Town	State	Zip Code

Secondary Insurance:	Company Name	ID #	Group #

Policyholder Info:

Last Name	First Name	Date of Birth (month/day/year)	Relationship to Patient

Street Address	Apt/Floor	Town	State	Zip Code

*Required Info

Sex Assigned at Birth:
☐ Male
☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Transgender FTM (Female-to-Male)
☐ Transgender MTF (Male-to-Female)
☐ Neither
☐ Other: _____
☐ Decline to answer

Sexual Orientation:
☐ Gay/ Lesbian/ Homosexual
☐ Straight/ heterosexual
☐ Bisexual
☐ Do not know
☐ Decline to answer
☐ Other: _____

Marital Status
☐ Single
☐ Separated
☐ Divorced
☐ Married
☐ Together
☐ Widowed

Employment Status:
☐ Retired
☐ Employed - Full Time
☐ Employed - Part Time
☐ Self-Employed
☐ Unemployed
☐ Student - Full Time
☐ Student - Part Time

Ethnicity: Hispanic: ☐ **YES** ☐ **NO**
Latino: ☐ **YES** ☐ **NO**
☐ Decline to answer

Race:
☐ White
☐ Asian
☐ Native American/Alaskan
☐ Black/African American
☐ Pacific Islander (near Asia)
☐ Other: _____
☐ Decline to answer

Language Preference:
☐ English ☐ Portuguese
☐ Spanish ☐ Other: _____

Other Questions: (required)

Do you want a translator? ☐ **YES** ☐ **NO**

Are you a Veteran? ☐ **YES** ☐ **NO**

Are you currently homeless? ☐ **YES** ☐ **NO**

How many people live in your home? _____

*Annual Income: (all people in home) $_____

Access

Email:

This email grants you access to your health information, including appointments & visit notes. You can use your secure account in a web browser or our encrypted mobile app.

If you DO NOT WANT TO BE ABLE access to your health information this way, you can DECLINE YOUR ACCESS by checking this box: ☐

*The CIFC Health receives Federal Grants which require us to ask for this information. – Note: Household income includes wages and salaries before taxes and deductions for all people who live in your home - even when not related.

- **Include:** paychecks, unemployment income, tips, social security (SSI & SSDI), public assistance (TANF), retirement/pension, rental income, interest income, child support income, alimony income for all persons who occupy a housing unit (house or apartment) whether or not they are related.
- **Do not include:** food stamps (SNAP), Section 8 or housing assistance.

Signature of Patient/Guardian: _____ **Date:** _____

CIFC Health

Financial Agreement & Assignment of benefits:

- I authorize the submission of a claim for Payment to Medicare, Medicaid or any other payer for any services provided to me or my children under 18 years of age as listed on the demographic sheet, now, in the past or in the future.
- I understand and agree that I am ultimately responsible for the balance for myself and all my identified children under 18 years of age as listed on the demographic sheet for any professional services rendered and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.
- I authorize payment of my medical benefits to be sent directly to CIFC Health or it's individual providers for services rendered for me and all my identified children under 18 years of age as listed on the demographic sheet**.** Should my insurance claim be denied for lack of eligibility or termination of coverage, I understand that I will be held responsible and intend to make payment for any balance due in those instances.
- I authorize CIFC Health to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to CIFC Health and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by CIFC Health, in the past, now or in the future.

Person Responsible for Payment: ☐ Patient ☐ Parent/ Guardian ☐ Spouse ☐ Other:

Last name	First name	M.I.	Phone	Date of Birth: (month/day/year)

Street Address	Apt/Flr	Town	State	Zip Code

Signature of Patient/Guardian: _____ **Date:** _____

Authorization to Treat

I hereby give permission to the staff of the CIFC Health Center to provide medical, dental, and behavioral health treatment, and vaccine administration. For emergency situations when I cannot be reached, I give permission for my minor dependents to be treated for the emergency conditions.

Signature of Patient/Guardian: _____ **Date:** _____

Health Records

I hereby authorize CIFC Health to obtain my health information, including utilizing electronic health information exchange entities (HIEs), whereby my health information may be received from and/or shared with external healthcare service professionals electronically for the purpose of my healthcare.

Signature of Patient/Guardian: _____ **Date:** _____

If you DO NOT wish to participate with Commonwell/Carequality you can DECLINE by checking this box: ☐

CIFC Health may obtain my medical records:

☐ **YES** - Authorization Form attached.
☐ **NO** - I do not wish to release or do not have prior medical records to release to CIFC Health.
NOTE: Missing medical records and health history increases patients' risks of treatment complications.

CIFC Health Office Use Only: (Card Copies for relevant Patient/Authorized Rep/Guardian)

1. Photo ID was:	2. Insurance Card was:	3. Documents Given	4. Financial Assistance Eligibility
☐ Copied/Scanned	☐ Copied/Scanned	☐ Welcome Letter/PCMH Packet	☐ Has current card: ___/___/___ (expiration date)
☐ On File & CONFIRMED	☐ On File & CONFIRMED	☐ ROI Update	☐ Has appointment: ___/___/___
	☐ Not with Patient Today		☐ Not currently eligible

5. Data Consent: ☐ Opt in/out was identified ☐ Response was documented in eCW

CIFC Health staff recipient's name:	staff signature:	date received & signed:
_____	_____	_____/_____/_____

CIFC Health

Patient HIPAA Consent Form:

I consent to the use or disclosure of my protected health information (PHI) by the medical providers and staff for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of CIFC Health. I understand that diagnosis or treatment of me by the providers of medical care in the CIFC HEALTH may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" PHI means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and data that identify me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of this practice. The CIFC Health is not required to agree to the restrictions that I may request. However, if the CIFC Health agrees to a restriction that I request, the restriction is binding on the members and employees of the CIFC Health.

I have the right to revoke this consent, in writing, at any time, except to the extent that a CIFC Health provider had taken action for the CIFC HEALTH on this consent.

I understand I have the right to review the CIFC Health's Privacy Notice before signing this document. The CIFC Health's Privacy Notice has been made available to me and describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations (TPO) of the CIFC Health. It describes my rights and the CIFC Health's duties with respect to my protected health information. A copy of this Privacy Notice is posted in the waiting room.

The CIFC Health reserves the right to change the privacy practices that are described in the Privacy Notice. I may obtain a revised Privacy Notice by calling the office and contacting the Privacy Officer.

Signature of Patient/Guardian: _____ **Printed Name:** _____ **Date:** _____

Office Use Only:

To be completed if the staff is unable to obtain a signature:

On _____/_____/_____, I attempted to obtain a written acknowledgement of receipt of the Privacy Notice from the above-named person but was unable to because:

- ☐ Patient declined to sign this Consent Form
- ☐ Patient did not understand this Consent Form
- ☐ Other [specify]: _____

Staff Member's Name: _____

Signature: _____

Date: _____

Tel: (203) 743-0100
Fax: (866) 800-7321

CIFC Health

120 Main Street, Danbury, CT 06810
70 Main Street, Danbury, CT 06810
152 West Street, Danbury, CT 06810

Health Information Authorization

Patient Last name | First name | Date of Birth: / / (month/day/year)

I hereby authorize the CIFC Health to: ☐ **Get** (receive) ☐ **Give** (send) ☐ **Share** (send & Receive) **my health information with the below person/agency.**

Person/Agency: ☐ Patient/Self | Phone ( ) | Fax ( )

Street Address | Town | State | Zip Code

Information to be Obtained:

- ☐ Lab Notes/ Reports/ Tests
- ☐ Visit Notes
- ☐ X-Ray Reports
- ☐ Billing Records
- ☐ Entire Record
- ☐ Other: _____
- ☐ Records related to treatment timeframe:
  from: ____/____/_____
  to: ____/____/_____

Purpose of Use:

- ☐ Patient's Request
- ☐ New Patient
- ☐ Moving
- ☐ School
- ☐ Specialist Referral
- ☐ PCP Request
- ☐ Transferring to other Practice
- ☐ Legal Investigation or Action
- ☐ Disability
- ☐ Social Security
- ☐ Insurance (other than payment)
- ☐ Other: _____

SPECIFIC AUTHORIZATION:

By signing below, I specifically authorize the disclosure/receipt of medical history information relating to sexually transmitted diseases, HIV/AIDS, genetic testing, mental health and substance abuse (except as indicated on this form).

Exclude (Do not share):

- ☐ Genetic testing
- ☐ Substance abuse
- ☐ HIV/AIDS
- ☐ Mental health*(see # 4.)
- ☐ Sexually Transmitted Diseases (STDs)

IMPORTANT INFORMATION:

By signing this authorization, I understand that:

1. This authorization shall expire one year from the date of the signature.
2. This authorization may be revoked in writing at any time by completing a CIFC Health revocation form, except to the extent that action has already been taken in reliance on this authorization.
3. I may inspect and copy the information to be used and disclosed under this authorization, and I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what is authorized by Connecticut State law.

*4. The disclosure/receipt of psychotherapy notes cannot be authorized by this form. A separate form is necessary for the receipt/disclosure of psychotherapy notes.

5. I am not required to sign this form to receive treatment, payment for care, enrollment or eligibility for benefits.
6. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.

AUTHORIZATION: ☐ Patient is signing consent ☐ Guardian/Authorized Representative

Patient's Printed Name | Patient's Signature | Date (month/day/year)

Authorized Rep/Guardian's Printed Name | Authorized Rep/Guardian's Signature | Date (month/day/year)

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Executor of Estate ☐ Conservator ☐ Other: _____

CIFC Health Office Use:
(only required when records are hand delivered.)

CIFC Health staff member verified the identity of the in-person recipient by:

☐ **Photo ID** ☐ **Photo on file**

CIFC Health member:

staff name: _____

signature: _____

date received & signed: _____/_____/_____

Notice to Recipient

As the recipient of this information, you may use this information only for the stated purposes. You may disclose this information to another party ONLY:

- With written authorization from the patient or the patient's legal representative;
- As required or authorized by state and/or federal law; or
- If urgently needed for the patient's continued care.

*** If this disclosure contains information relating to HIV, mental health, alcohol or drug abuse education, training, treatment, rehabilitation or research, the following applies:** The information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal regulations and/or state law prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.