LSS FAITH MISSION
Homeless Shelter & Services

The Health Center at Faith Mission

Patient Registration

Date: _____

Patient Information

Full Name:_____ Date:_____
Last *First* *M.I.*

Inmate/Correctional Identification Number:_____

Preferred Name:_____ Preferred Pronouns?_____

Address:_____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone:_____ Cell:_____

Date of Birth:_____ Social Security No:_____

Email:_____

Emergency Contact Information

Emergency Contact Name:_____ Phone No:_____

Relationship to emergency contact: _____

May we release Protected Health Information to your emergency contact? ☐ Yes ☐ No

Demographic Information

Marital Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widow ☐ Other

Race: ☐ African American/Black ☐ Asian ☐ Pacific Islander ☐ White

☐ Native American ☐ Other: _____

Ethnicity (Please Select One): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Primary Language Spoken: ☐ English ☐ Spanish ☐ Arabic ☐ Bengali

☐ Other: _____

Will you require a translator? ☐ Yes ☐ No

Insurance Information

Do you Currently Have Health Insurance? ☐ Yes ☐ No

If No would you like assistance with obtaining insurance? ☐ Yes ☐ No

Health Plan I Currently Have:

☐ Buckeye ☐ CareSource ☐ Molina ☐ United HealthCare ☐ Aetna ☐ Humana
☐ Anthem ☐ Medicare ☐ Other: _____

Housing Information

Are you Currently Homeless? ☐ Yes ☐ No

☐ Shelter/ Bed#:_____ ☐ Transitional Shelter ☐ Street

☐ Doubling up with Family or Friends ☐ Permanent Supportive Housing

☐ No housing plan or inconsistent Housing

Do you live in Public Housing? ☐ Yes ☐ No

Are you in Columbus for the season and reside elsewhere? ☐ Yes ☐ No

Additional Information

Is Columbus your Primary Residence? ☐ Yes ☐ No

If No, where do you reside: _____

Are you a Migrant Worker? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Sexual Orientation: ☐ Lesbian or Gay ☐ Bisexual ☐ Do not know ☐ Straight

☐ Choose not to disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

☐ Non-Binary ☐ Choose not to disclose

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex ☐ Choose not to disclose

How did you hear about the Health Center? _____

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Household Size and Income Declaration

Name:	Date:

Total Number or people in my household (please include yourself): _____
(This number should include all people who you are financially responsible for in the household. This means you are responsible for more than half of their expenses and needs.)

☐ **I hereby certify that there is no income in my household**

☐ **I hereby certify that I am a client of the Health Center at Faith Mission and I, or someone in my household, receives income from the following source(s):**

Wages from employment including commissions, tips, bonuses, fees, etc. **Self** **Spouse** **Relative** **Non-Related Adult**	$_____ $_____ $_____ $_____
Unemployment, disability, or other public assistance payments	$_____
Income from operating a business, including being self-employed	$_____
Rental income from any type of property	$_____
Social Security Payments	$_____
Annuities, insecure policies, retirement funds, pensions, or death benefits	$_____
Interest or dividends from assets	$_____
Any other source not named above. Source: _____	$_____
Total:	**$_____**

Under the penalty of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge. The undersigned further understands that providing false representation herein constitutes an act of fraud. False, misleading, or incomplete income information may result in the termination of services.

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_____	_____	____/____/____
Client Name/ Authorized Person (Print)	**Client Signature/ Authorized Person Signature**	**Date**

_____	_____	____/____/____
Staff Name (Print)	**Staff Signature**	**Date**

Informed Consent for Treatment

I hereby consent to the provision of diagnosis, care, and/or treatment by The Health Center at Faith Mission whether it be an in-person visit with my provider or a tele-medicine visit with my provider and I hereby acknowledge that such consent will remain in effect unless and until I cancel consent in writing.

I have been asked to provide income and medical insurance information for billing purposes but understand that failure to provide such information will not preclude me from being given care and/or treatment.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I hereby acknowledge and understand that, by signing this informed consent patient form, I am giving informed consent to the provision of diagnosis, care, and/or treatment by THE HEALTH CENTER AT FAITH MISSION. I cannot bring a tort or other similar action, including an action on a medical, dental, podiatric, optometric, behavioral health, or other health-related claim, against THE HEALTH CENTER AT FAITH MISSION unless the action or mission of the volunteer providers at The HEALTH CENTER AT FAITH MISSION constitutes willful or wanton misconduct.

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY *Our entire staff adheres to professional standards, legal and ethical, regarding confidentiality. By signing I understand, statutes require and/or permit, us to notify specified others in situations of expected homicide, suicide, and child or elder abuse or neglect.*

_____	_____	____/____/____
Name Client/Authorized Person to Permit Disclosure	**Signature Client/ Authorized Person to Permit Disclosure**	**Date**

_____	_____	____/____/____
Staff/Witness Name	**Staff/Witness Signature**	**Date**

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HIPAA

HIPAA Patient Consent Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

- The practice reserves the right to obtain and/or release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on myself, for insurance/billing purposes, healthcare operation or mental health and substance abuse,(including direct or indirect treatment by other healthcare providers involved in my treatment).
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

This consent was signed by (PRINT NAME PLEASE): _____

Signature:_____Date:_____

Signature of the Patient or Patient Representative

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Witness:_____Date:_____

For an unabridged copy of our HIPAA Notice of Privacy practices, please ask a staff member.

SDH

For Office use Only
Date Scanned:
Staff Initials:

Social Determinants of Health

What is your current housing situation?

- ☐ **I have housing.**
- ☐ **I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park)**
- ☐ **I choose not to answer this question.**

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

What is the highest level of school that you have finished?

- ☐ Less than a high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question.

What is your current work situation?

- ☐ Part time or temporary work
- ☐ Unemployed and seeking work.
- ☐ Full time work
- ☐ Otherwise, unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver)
- ☐ I choose not to answer this question.

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Childcare
- ☐ Medicine or any health care (medical, dental, mental health or vision)
- ☐ Phone
- ☐ Other (please write in notes)

- ☐ I do not have problems meeting my needs.
- ☐ I choose not to answer this question.

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications.
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living.
- ☐ No
- ☐ I choose not to answer this question.

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question.

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question.

Additional Questions

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

Are you a refugee?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

What country are you from?

- ☐ United States
- ☐ Country Other than the United States (please write in notes)
  - _____
- ☐ I choose not to answer this question.

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Choose not to answer this question.

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year.

Would like assistance with any of the above barriers that you may be experiencing? We have staff members on our team that can help.

○ Yes ○ No