LSS Health Center
245 N Grant Ave.
Columbus, Ohio 43215
Phone: (614) 224-0747
Fax: (855) 208-4527

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

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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 LSS HEALTH CENTER 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 LSS HEALTH CENTER 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 LSS HEALTH CENTER. 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 LSS HEALTH CENTER unless the action or mission of the volunteer providers at The LSS HEALTH CENTER 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