Codman Square
Health Center

Codman Square Health Center - Mobile Health Unit
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CSHC-MHU **CONSENT & DEMOGRAPHIC** FORM

PATIENT DEMOGRAPHICS

Student's Name: _____ **Date of Birth:** _____ /_____ /_____

Address: _____ **City:** _____, **MA**

Zip: _____ **Phone: home/cell** *(please specify)* _____

Email: _____

Sex/Gender:
☐ Male ☐ Female
☐ Trans; FTM ☐ Trans; MTF
☐ Gender nonconforming
☐ Other

Education Level
☐ High School
☐ Some High School
☐ Middle School
☐ Elementary School
☐ Kindergarten
☐ Pre-School

Racial/Ethnic Group
☐ Asian
☐ Hispanic Non-White
☐ Black Non-Hispanic
☐ White (Caucasian)
☐ Other: _____
_____

Primary Language Spoken
☐ English
☐ Haitian Creole
☐ Spanish
☐ Cape Verdean
☐ Vietnamese
☐ Portuguese
☐ Other: _____

Interpreter Needed?
☐ Yes ☐ No
If yes, language: _____

Student Employment *(check one)***:**
☐ Student ☐ Part-Time ☐ Full-Time

PATIENT VISIT AND INSURANCE INFORMATION

Has the student ever been seen at any Codman Square Health Center location for any services? ☐ Yes ☐ No

Emergency Contact Name: _____ **Phone:** _____

Relationship _____ **Does the person know that you are a patient here?** ☐ Yes ☐ No

Does the student have a Primary Care Provider? ☐ Yes ☐ No **If Yes, who is the Primary Care Provider?** *(name, address, phone, email)* _____

_____

_____ **If No, would you like your student to have a Primary Care Provider at Codman?** ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No **Insurance:** _____ **Policy/Card ID#** _____

Name of Insurance Policyholder *(e.g. self, parent, guardian)***:** _____ **Date of Birth:** _____ /_____ /_____ **Email:** _____

Please provide a billing address below, if different from above:

Address _____ **City** _____, **MA** **Zip:** _____

Sliding Fee Discount Program: Codman Square Health Center offers a sliding fee discount program to all Community Health Center individuals and families with annual incomes at or below 200% of current DHHS Federal Poverty Guidelines who could be either uninsured or underinsured. No aspect of the sliding fee scale discount program (SFSD), including Codman Square Health Center's fees themselves, the procedures for assessing patient eligibility, or the procedures for collecting payments, will create barriers to health care services.

CONSENT TO TREAT AND BILL

If you are under 18 years of age, your parent/guardian must sign this consent form. **If you are 18 years or older,** you may sign the consent form.

I give consent to receive medical and behavioral health services by Codman Square Health Center at the Mobile Health Clinic. I authorize Codman Square Health Center to provide necessary evaluations, diagnostic assessments, individual and group counseling, and management of my wellness in accordance with the laws of the Commonwealth of Massachusetts. I authorize engagement with my primary care provider for care that cannot be provided on site. I understand that the health center records, including behavioral health records, will be secured, and maintained as confidential medical records. I understand that I will receive no services from Codman Square Health Center at Mobile Health Clinic unless a consent form is on file. I understand that I may at any time withdraw this consent.

I hereby authorize Codman Square Health Center Mobile Health Clinic to render such services as may be deemed necessary to me/my children and review my medical record for quality-of-care purposes. I also authorize the release of all necessary information to my insurance plan(s)/payor(s) as well as other medical providers for payment, quality of care and treatment purposes. Furthermore, I assign to Codman Square Health Center authority to claim and collect medical insurance benefits and payments on my behalf. I accept that payment for services that my insurance plan(s) pay(s) to me directly or will not cover will be my responsibility in addition to any co-pays, coinsurance and/or deductibles.

■ Behavioral Health ■ Medical Tests & Services ■ Sports Physicals ■ Immunizations & Vaccines ■ Health Education *(age-appropriate)* ■ Point-of-Care Testing

Coordination of Care through collaboration with another Codman Square Health Center location, affiliated group providers, mobile, or community provider:
■ Dental Services ■ Vision Services ■ Radiology Services ■ Specialty Care ■ Laboratory Services

NOTICE OF PRIVACY PRACTICES

☐ I have received an updated copy of the Codman Square Health Center Notice of Privacy Practices.

This authorization is good for the duration of one year from the date of signature or until indicated. You may decide to opt out and revoke consent to treat at any time for any service. ☐ **Opt out – Date of Expiration:** _____ /_____ /_____ ☐ **Revoke/limit service** *(please specify)***:** _____

_____ _____
Signature Date

_____ _____
Print Name Date

How did you hear about us? ☐ Family/Friend Referral ☐ codman.org ☐ Google/Web Search ☐ Social Media ☐ Advertisement ☐ Community Event ☐ School Communication

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