



Patient Information

Last Name First Name		Middle Initial	Date of Birth: month/day/year	
Street Address:		Unit #	City	State Zip Code
Phone 1:	Primary Contact? <input type="checkbox"/>	Phone 2:	Primary Contact? <input type="checkbox"/>	Student's Cell phone Primary Contact? <input type="checkbox"/>
Phone 1 is OK for CONFIDENTIAL messages: <input type="checkbox"/> YES <input type="checkbox"/> NO		Phone 2 is OK for CONFIDENTIAL messages: <input type="checkbox"/> YES <input type="checkbox"/> NO		Student's Cell is OK for CONFIDENTIAL messages: <input type="checkbox"/> YES <input type="checkbox"/> NO
How do you want to receive reminders and notifications? <input type="checkbox"/> Text <input type="checkbox"/> Voice Message (if voice message, select: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work)				

Contact

Emergency Contact 1: Name:		Relation:	Phone 1: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
To Medical Contact 1, CIFC Health can:		1) Disclose your medical information? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) Leave a detailed message with them? <input type="checkbox"/> YES <input type="checkbox"/> NO 3) Contact this person in an emergency? <input type="checkbox"/> YES <input type="checkbox"/> NO	Phone 2: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Emergency Contact 2: Name:		Relation:	Phone 1: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
To Medical Contact 2, CIFC Health can:		1) Disclose your medical information? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) Leave a detailed message with them? <input type="checkbox"/> YES <input type="checkbox"/> NO 3) Contact this person in an emergency? <input type="checkbox"/> YES <input type="checkbox"/> NO	Phone 2: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Do you have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO		Can we help you apply for? : <input type="checkbox"/> Husky/Medicaid <input type="checkbox"/> Health Insurance - Access Health CT <input type="checkbox"/> Financial Assistance - Our in-house sliding-fee scale program	
Which pharmacy do you use?		Who is your primary care provider (PCP)?	

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 Information

Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Together <input type="checkbox"/> Widowed	Employment Status: <input type="checkbox"/> Retired <input type="checkbox"/> Employed- Full time <input type="checkbox"/> Employed- Part time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student-Full Time <input type="checkbox"/> Student-Part Time	Ethnicity <small>select all that apply</small> Hispanic/Latino: <input type="checkbox"/> Yes, from which country? _____ <input type="checkbox"/> No Decline to answer	Other questions: (required) Do you want a translator: <input type="checkbox"/> YES <input type="checkbox"/> NO Are you a Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO
			Race <small>select all that apply</small> <input type="checkbox"/> Asian: from which country? _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Black/ African American <input type="checkbox"/> Native American/ Alaskan <input type="checkbox"/> White <input type="checkbox"/> Decline to answer	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				

Access

E-mail:	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: <input type="checkbox"/>	

Income

CIFC Health receives Federal Grants which require us to ask for this information.

How many people are in your household? _____ Household Income: \$ _____

Weekly: How many weeks do you work each year? _____
 Monthly: How many months do you work each year? _____
 Annually

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

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: <input type="checkbox"/> Patient <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other:				
Last name	First name	M.I.	Phone	Date of Birth: (month/day/year)

Street Address	Apt/ Floor	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 past and present medical information to CIFC Health.
NOTE: Missing medical record information, as well as the patient's health history, increases the risk of complications during treatment.

Please select the SBHC the student is enrolling in:

Henry Abbott Technical High School P: (203)731-8274 F: (203)731-8275

Grade/Cluster _____