Howard Brown Health

Client Registration Form

Today's Date _____/_____/_____

How did you hear about Howard Brown Health?

- ☐ TPAN
- ☐ Thresholds
- ☐ Family/Friend
- ☐ Internet search
- ☐ Social media (Facebook, Instagram, Twitter)
- ☐ Online advertisement
- ☐ Newspaper or magazine advertisement
- ☐ CTA advertisement
- ☐ Medical provider/hospital
- ☐ Other _____

We would like to keep you up to date with Howard Brown's programs, events, workshops, support groups, and other news. If you do not wish to receive these types of digital communications, please check the box on the right. ☐

CLIENT INFORMATION (PLEASE PRESENT YOUR PHOTO IDENTIFICATION AND INSURANCE CARD WITH THIS PAPERWORK)

☐Mr. ☐Ms. ☐Mrs. ☐Dr. ☐None | Legal Name: First | Middle | Last | Suffix (Jr, Sr, II, III etc.)

Preferred Name/Nickname | Birth Date Mon Day Year _____/_____/_____ | Are you the patient responsible for all Bills and Insurance? _____ If not, please list name of Responsible person _____

Marital Status: ☐single ☐partnered ☐married ☐divorced ☐separated ☐widowed ☐ other

Street Address | Apt/STE/Unit | City | State | Zip

Mobile/Cell Phone ( ) | Home Phone ( ) | Email Address @ | I prefer electronic Statements ☐

Best way to contact me/leave messages (check all that apply): ☐ Phone/ Voicemail ☐ E-mail ☐ U.S. mail

Gender Listed on Insurance/Driver's License ☐Male ☐Female | Social Security Number _____-_____-_____

Occupation | Employer | Work Phone ( )

Emergency Contact | Phone ( ) | Relationship to Client

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Legal Name of Person Responsible for Bill ☐ Same as Above | Relationship to client if client is not responsible party

Birth Date (if client is not responsible party) _____/_____/_____ | Social Sec Number _____-_____-_____

Street Address (if different) | City | State | Zip

Email Address | Home Phone ( ) | Cell Phone ( ) | Work Phone ( )

Primary Insurance Company | Subscriber's Name | ID# | Group#

Secondary Insurance Company | Subscriber's Name | ID# | Group#

Rev. 2/8/2018

Howard Brown Health

Client Registration Form

INCOME: (PLEASE GIVE VERIFICATION OF INCOME TO A PATIENT REPRESENTATIVE IF APPLYING FOR SLIDING FEE or RYAN WHITE GRANT FUNDS)

Annual Income: $ _____ **Household Annual income: $**_____

Number of adults in household (including you):_____ **Number of children in household (under 18 years old):** _____

HBH receives funding to provide financial benefits to clients. By providing your proof of your income and HBH can determine whether you are eligible for these benefits? Proof of your income includes, but is not limited to, your last two to three pay stubs, last year's W-2 form, last year's tax return or paperwork approved by a HBH financial counselor.

By signing, I understand that based on my income, I may be eligible for the HBH sliding scale or Ryan White financial benefits. However, I must provide proof of income to receive these benefits. **I understand that I will be charged the full fee of** my visit if I do not bring in documentation of income by my third visit or within 60 days of my first visit, whichever comes first. I understand that I will never be refused services at HBH because I do not provide documentation ofincome.

DISCLAIMER STATEMENT

I authorize Howard Brown Health to submit claims to my insurance carrier and to release any medical information Necessary to process all claims. I also authorize payment for any medical benefits to Howard Brown Health for all services provided until further notified for this account. I agree that I am financially responsible for any co-pay and self-pay balance at the time of service, and any balance that may be due after the claims have been submitted to my insurance.

Client Signature_____Date_____/_____/ _____

Office use only:

- ☐ **All Documents signed**
- ☐ **ID and Insurance and POI collected and scanned**
- ☐ **Correct Insurance information entered**
- ☐ **Preferred Name entered**

Initialed: _____

Howard Brown Health

Demographics Form

Today's Date
_____/ _____/ 20_____

Name on ID/Insurance: First	Middle	Last	New Patient? Yes No

Chosen First Name: Birth Date: Month / Day / Year

Have you attended Outreach Events Yes No Do you receive public benefits (SNAP, medical card, etc.) Yes No

Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Only my name ☐ No preference ☐ A pronoun not listed _____

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders; we understand that current demographic categories do not adequately capture our individual identities. Please help us serve you better by selecting the best answers to these questions. Thank you.

Preferred Spoken/Written Language:

☐ English ☐ Spanish ☐ Polish
☐ American Sign Language
☐ _____

Language interpretation services needed?

☐ No
☐ Yes, language _____

Sexual Orientation:

☐ Lesbian ☐ Straight
☐ Gay ☐ Something else
☐ Bisexual ☐ Questioning
☐ Queer ☐ Decline to answer

Gender Identity:

☐ Male/Man
☐ Female/Woman
☐ Trans Male/Trans Man
☐ Trans Female/Trans Woman
☐ Genderqueer/Gender nonconforming
☐ Something else
☐ Decline to answer

Sex Assigned at Birth:

☐ Male ☐ Intersex
☐ Female ☐ Decline to answer

Race: *Select up to two*

☐ American Indian/Alaska Native
☐ Black and/or African American
☐ White/Caucasian

Asian

☐ Asian Indian ☐ Korean
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Other
☐ Japanese

Native Hawaiian/Pacific Islander

☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

☐ Decline to answer

Ethnicity:

Hispanic/Latino

☐ Mexican
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic/Latino

☐ Not Hispanic/Latino
☐ Decline to answer

Housing Status:

☐ Permanent Housing
☐ Non-permanent Housing
☐ Institution
☐ Homeless
  ☐ Street
  ☐ Homeless Shelter
  ☐ Transitional
  ☐ Doubling Up (not paying rent)
  ☐ Other
  ☐ Decline to answer
☐ Decline to answer

Completed Level of Education:

☐ 1-8 Years
☐ High School Degree
☐ GED
☐ Associate's College Degree
☐ Trade School
☐ Bachelor's College Degree
☐ Master's Degree
☐ Doctorate Degree

Veteran: ☐ Yes ☐ No

Agricultural Worker: ☐ Yes ☐ No

Income

Anticipated annual household income for this year:

Total # people living in household, including you:

I verify the above information is correct to the best of my knowledge.

X_____ ___/___/____
Patient Signature Date

Howard Brown conducts research to help the communities we serve. If you are **NOT** interested in participating, please check the box below.

☐ **Do not** contact me about research

Sliding Fee Application

Effective 08/15/2016

It is the policy of Howard Brown Health (HBH) to provide quality medical care and behavioral health services to all persons in need of care, regardless of income and/or the inability to pay. Please complete the following information so that HBH will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months and you will be required to provide updated proof of income.

Patient's Name: _____**Preferred Name**: _____

Date of Birth: _____ **Last four digits of Social Security Number**: _____

Do you have commercial health insurance, Medicare, and/or Medicaid?

☐ Yes ☐ No ☐ Not Sure

HOUSEHOLD

A "household" includes legal **children**, a civil union **partner** or married **spouse**, and legal **dependents**. Please list the name of individuals in your household and relation to you. Please use the back of this form for additional space.

Names of individual living in household (including yourself)	Relation to you
TOTAL number of people in household:	

ANNUAL HOUSEHOLD INCOME

Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tips, etc				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other				
TOTAL INCOME				

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the **full fee of my visit** if I do not bring in documentation of income by my **third visit or within 60 days of my first visit**, whichever comes first. I understand that I am required to notify Howard Brown Health Center if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable) :_____

FOR INTERNAL USE ONLY

☐ $0 - RW L1 0-100%
☐ $5 - Non-RW 0-100%
☐ $10 101-125%
☐ $15 126-150%
☐ $20 - 151-175%
☐ $25 – 176-200%
☐ Full Fee (not eligible) greater than 200%

Reviewed By	
Effective Date	
Termination Date	

Howard Brown Health

Registration Receipt of Documents

Legal Name of Client: _____

Preferred Name of Client: _____

Date of Birth: _____/_____/_____

HIPAA Privacy Practices Acknowledgement

Notice of Privacy: Howard Brown Health's (HBH) Notice of Privacy Practices was given to you when you registered. By initialing below, you acknowledge that you have received the Notice of Privacy Practices.

Initial Here_____

Client Rights and Responsibilities Acknowledgement

Rights and Responsibilities: Copy of HBH's Client Rights and Responsibilities was given to you when you Registered. You have read the Rights and Responsibilities and had any questions about them answered. By initialing below, you acknowledge that you received a copy of the Rights and Responsibilities and you understand them.

Initial Here_____

Complaint Process Acknowledgement

Grievance Policy: HBH's Complaint Process was given to you when you registered. By initialing below, you acknowledge that you received the Complaint Process.

Initial Here_____

Consent for Treatment Acknowledgement

Consent for Treatment: HBH's Consent for Treatment was given to you when you registered. You have read the Consent for Treatment and had any questions about it answered. By initialing below, you acknowledge that you received the Consent for Treatment and you understand it.

Initial Here_____

Client Signature _____ Date _____

Guardian Signature _____ Date _____
(If different from the client listed)

Employee Witness to Signature _____ Date _____

Howard Brown Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____ Date of Birth:_____ SSN:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

I hereby authorize and request that: ***Howard Brown Health,*** *Medical Records Department*, *4025 N. Sheridan Rd., Chicago, IL 60613*
773-388-8936 fax / 773-388-8667 phone

disclose information *TO* ____ **receive information *FROM*** ____ **exchange information with** ____:

_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Purpose of disclosure:_____ **Date or range of dates of requested information:**_____

I request the release of the following information (INITIAL ALL THAT APPLY):

_____COMPLETE HEALTH RECORD	_____X-rays	_____Lab Tests/Reports
_____Discharge Summary	_____Radiology	_____Case Management Notes/Reports
_____History and Physical Exams	_____EKG/EEG	_____Other (specify):_____
_____Physician/Consultation Reports	_____Progress Notes	_____

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

_____Mental/Behavioral Health	_____Sexually Transmitted Diseases
_____Developmental Disability	_____HIV/AIDS
_____Alcohol/Substance Abuse	_____DNA Testing/Genetic Disorders
_____Domestic Violence/Sexual Assault	_____ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

If requesting email delivery, you must initial and complete the following: _____(initial) I hereby authorize that any of the information requested above may be delivered via secure, encrypted email to the following email address:_____

This Authorization is valid until (SELECT DATE NO MORE THAN 12 MONTHS FROM SIGNATURE):_____

I UNDERSTAND THAT THIS AUTHORIZATON IS VOLUNTARY, AND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ADDRESS ABOVE. ANY REVOCATION DOES NOT APPLY TO RECORDS ALREADY RELEASED IN GOOD FAITH PURSUANT TO THE ABOVE RELEASE. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION BEING DISCLOSED PURSUANT TO THIS AUTHORIZATION. I UNDERSTAND THAT A MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION, BUT IT HAS BEEN EXPLAINED TO ME THAT IF I DECLINE TO CONSENT TO THIS RELEASE OF INFORMATION, THE FOLLOWING CONSEQUENCES MAY APPLY, AS RELEVANT: MY PROVIDERS MAY BE UNABLE TO COORDINATE MY CARE; I MAY BE UNABLE TO APPLY FOR THIS PROGRAM; AND/OR THE REQUESTED RECORDS MAY NOT BE RELEASED. ANY COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____ _____ _____
Signature of Person Authorizing Release | Date | Signature of Witness (Encouraged but not Required) | Date

NOTE: This Authorization must be completed in its entirety in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:_____

*** Requests for records may incur a charge, if and as allowed by law. ***

Rev. 11/2019

Howard Brown Health

Consent for Treatment

I agree to receive routine treatments and procedures that my medical and/or behavioral health provider believe will help improve my health. A "routine" treatment or procedure is one that is regularly offered in an outpatient center like Howard Brown Health (HBH). I understand that my medical and/or behavioral health provider will work with me to diagnose and treat my health issues. Therefore, I agree to receive medicine and/or treatment that my medical and/or behavioral health provider believes will help to diagnose and/or treat problems I am having, or improve my health and wellness.

Routine medical treatments and procedures at HBH may include:

- Asking questions about my medical history and my health
- A physical exam
- Measuring my blood pressure, temperature, height and weight
- Prescribing and/or giving me medicine
- Having blood drawn for tests
- Screening for infectious diseases such as HIV, HCV, Syphilis, Chlamydia, or Gonorrhea
- Other simple, common procedures

Routine therapy treatments and procedures may include:

- Asking questions about my mental health history and how I am feeling
- Discussing my concerns and problems
- Creating a plan for therapy together

If my provider recommends any "non-routine" treatments, procedures or medicines, we will talk about that separately. I may get a special consent form for care that is non-routine that will be explained and reviewed with me by my medical or behavioral health provider.

I understand that:

- HBH cannot promise that I will get good results from the treatment, procedures, services and medicine I receive

- My medical and/or behavioral health provider will explain the benefits and possible risks from the routine treatment, procedures, services and medication I may receive and will tell me about other options too

- I will have a chance to ask questions and get answers I understand about any concerns I have

- I will be able to choose the treatments, procedures, services and medicines that are suggested to me. I can choose to take some and refuse some of the treatments, procedures, services and medicines that are suggested to me.

- I can change my mind about the services I want at any time, but HBH cannot reverse care I have already gotten.

- If I refuse to consent to all treatment, I cannot be treated at HBH. Instead, HBH will give me referrals to other providers or health care agencies.

I understand that my providers at HBH work together to provide integrated health care and to provide me the best health care experience. To do that, information about me may be shared with other necessary HBH staff involved in my care, such as my nurse, my medical provider and my behavioral health provider.

I understand that information I give HBH is confidential and cannot be shared with anyone outside of HBH without my written permission except as required by law. I understand that if eligible for and participating in HIV or HCV screening under an IDPH testing grant, my health information will be reported to Illinois Department of Public Health via Provide Enterprise Software. I understand that HBH is required to report information to the State of Illinois Immunization Registry. I understand that HBH may have to share some information with outside organizations about me without my permission when any of the following things happen:

- If HBH finds out about or suspects child abuse, elder abuse or abuse of someone that is disabled, it is required to report information to protect the person that may be abused.

- If HBH believes that I am at a high risk of hurting or killing myself or someone else, HBH has to help keep me and the other person safe.

For more information about how my information can, cannot or must be shared, I can review the HBH Privacy Policies and the HBH Patient Rights and Responsibilities.

Howard Brown Health

Statement of Client Rights

You have the right:

- To access services which will not be denied on the basis of economic status, disability, national origin, ethnicity, race, religion, gender, gender presentation or gender identity, sexual orientation or HIV status (in accordance with the Americans with Disabilities Act).
- To be treated as an important member of your healthcare team and to have your choices and needs valued.
- To receive care in a safe and secure environment, free from physical, verbal or sexual harassment, swearing or disorderly conduct.
- To have all information about you, including HIV status, treated in a confidential manner in accordance with Federal and State laws.
- To receive information about your diagnosis, medical condition and treatment in language you understand.
- To request a copy of your medical records.
- To be informed of services, research opportunities and programs available to you at Howard Brown Health (HBH).
- To receive services from other organizations with or without the assistance of HBH staff.
- To refuse service or end your participation in any or all services provided by HBH and to have the consequences of this decision explained to you without punishment or penalty.
- To know where and how to register a complaint or concern, and to know that your complaint or concern will be taken seriously.
- To know that you will not be penalized for registering a complaint or concern.
- To ask for the services of an interpreter and to know that HBH will provide one.
- To request a meeting with a financial counselor when your financial circumstances or insured status have changed to have your assessed payments reevaluated.
- To continue to receive services if your financial circumstances or insured status has changed.
- To contact HBH billing agency to raise concern about any errors in your bill.
- To be aware that HBH is a teaching institution and those resident physicians, medical students, student nurses, psychology and social work students and other supervised health care providers-in-training may be involved in your care.

Howard Brown Health

Statement of Client Responsibilities

You have the responsibility:

- To be an active member of your health care team and to follow the treatment plan that you and your provider agree upon.
- To ask questions and tell us when you do not understand a treatment option or decision being considered.
- To help your provider understand your concerns and the way your life circumstances may impact your care.
- To keep your provider informed of all services you are receiving from outside agencies or individuals.
- To notify Howard Brown Health (HBH) immediately if your contact or personal information and/or if your insured status or financial circumstances change.
- To come to your appointment without being under the influence of alcohol or illicit drugs. If you are under the influence of alcohol or other illicit substances, you will not be seen and you will be asked to reschedule your appointment.
- To attend your appointment and to arrive 10-15 minutes before your scheduled appointment time.
    - Please provide at least 24 hours advanced notice if you need to cancel your appointment.
- To answer all questions and fill out all paperwork completely and honestly, including (but not limited to) information about your financial status, health conditions and care received elsewhere.
- To treat everyone at HBH with respect. Physical, verbal or sexual harassment of staff or other clients, swearing or disorderly conduct will not be tolerated. This type of behavior may result in immediate termination from HBH services.
- To not talk about or share anything you learn about other people who receive care at HBH.
- To pay your bills or make arrangements with HBH to meet your financial obligations in a timely manner.
- To share your compliments and concerns, and provide suggestions that will help us provide you the best care possible.

Howard Brown Health

Description of Services and Complaint Process

Howard Brown Health (HBH) promotes the health and well-being of gay, lesbian, bisexual, and transgender people and enhances their lives through health care and wellness programs. HBH offers primary medical care, counseling, and case management services. HBH also has a range of research opportunities in which clients can participate. Our services are designed to serve gay, lesbian, bisexual and transgender people; people impacted by HIV/AIDS and allies in a confidential, supportive environment.

DESCRIPTION OF SERVICES

MEDICAL CARE: Anyone is eligible to receive care based on availability regardless of ability to pay. Services include: comprehensive primary care, HIV/STI testing and counseling.

COUNSELING: Anyone is eligible to receive care based on availability regardless of ability to pay. Services include: individual, couples, family and group counseling, substance abuse counseling, support groups, therapy groups, smoking cessation groups, workshops, and referrals.

CASE MANAGEMENT: Anyone who is living with HIV is eligible to receive case management based on availability. Services include: needs assessment, development of service plan, medical case management, treatment adherence, support with accessing benefits and entitlement programs, resource referral, emergency financial aid (based on need), transportation, legal assistance, and Department of Rehabilitation Services (DRS) home services coordination.

YOUTH SERVICES: Anyone 12-24 years of age is eligible to receive services based on availability regardless of the ability to pay. Services include: educational/vocational, drop-in, STI/HIV testing and counseling, medical services, resource advocacy, counseling, mentoring, and group programs.

RESEARCH: Eligibility to participate in research opportunities depends on the specific needs of each research study. Research participation might include: behavioral interventions, surveys, and clinical trials focused on health issues, such as HIV/AIDS, STDs, cancer screenings, and smoking cessation.

Effective 12/18/2013
Updated 6/10/2014*

COMPLAINT PROCESS

We appreciate client feedback and encourage you to offer us the opportunity to address any concerns you may have. If you feel that you have not been treated fairly, that your rights have been violated or that the quality of the services you received were poor, please consider taking one of the following steps:

- If you feel comfortable, please discuss your concern with the staff member offering your services. The staff member will attempt to resolve the complaint and will inform you about the available alternatives or actions they can take to resolve your concern.

- If you are not comfortable speaking directly with the staff member or if you are still dissatisfied after speaking with the staff member, you can speak with that staff member's supervisor. The staff member's supervisor will attempt to resolve the complaint and will inform you about the available alternatives or actions they can take to resolve your concern... If the staff member's supervisor is not immediately available, the supervisor will attempt to contact you as soon as possible, but no later than 2 business days.

- If you are unsatisfied with the supervisor's response and proposed solution, you can talk to the department director for a response and proposed resolution.

- Finally, if you are not comfortable speaking directly with the department director, or you remain dissatisfied after speaking with them, you can talk to HBH's grievance officer. You may leave a message with them at 773-572-8361. The grievance officer will contact you within 7 days of receiving the message.

- If at any time, you are uncomfortable speaking with anyone directly about your complaint, you fill out a Client/Patient Complaint and Grievance Form that includes a written description of 1) the circumstances surrounding the complaint, 2) actions HBH staff took to resolve the complaint to date and 3) the action you are requesting to resolve the complaint.

Client/Patient Complaint and Grievance Forms are available at the front desk and on the HBH website. You may leave the Form at the front desk or mail the form to the Grievance Officer at 4025 North Sheridan Road, Chicago, IL 60613.

Clients/Patients, who have a complaint or grievance about HBH services funded through the Ryan White Program, can contact The Center for Conflict Resolution (CCR) for free at 1-866-CARE-212. CCR provides conciliation and mediation services by a neutral person to help the client/patient and HBH discuss and problem solve concerns in hopes of finding resolution. Clients/Patients can call CCR at any point in the complaint or grievance process and do not need to follow the steps above before calling CCR.

Case management clients/patients receiving services funded through the AIDS Foundation of Chicago (AFC) who is dissatisfied with the resolution of their complaint or grievance at HBH can call Michael Grego at the AIDS Foundation of Chicago at (312) 784-9089.

Effective 12/18/2013
Updated 6/10/2014*