THOMAS CHITTENDEN
HEALTH CENTER

PATIENT REGISTRATION AND CONSENT FORM

PATIENT INFORMATION

First Name _____ Last Name _____ MI____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Primary phone _____ ○ Mobile ○ Landline Secondary phone _____ ○ Mobile ○ Landline

Email address _____

Guardian Name (if under age 18): _____ Guardian DOB: _____

Guardian address (if different than patient) _____

Legal sex _____

*While TCHC recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Marital Status _____
Gender Identity _____
Preferred Pronoun _____

EMERGENCY CONTACT

Name _____ Phone # _____ Relationship _____

Due to recent changes in Federal regulations we are required to collect the following information for all Thomas Chittenden Health Center patients.

Race: ☐ Caucasian/White ☐ Asian-American ☐ African-American ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Other _____ ☐ Decline to answer

Preferred Language: ☐ English ☐ Other (please specify) _____ ☐ Decline to answer

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

CONSENT

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I consent to allow Thomas Chittenden Health Center to use or disclose my protected health information for treatment, payment and health care operations

1. **Treatment** means the provision, coordination or management of health care and related services by one or more health care providers.
2. **Payment** means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provisions of health care.
3. **Health care operations** means conducting quality assessment and improvement of activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Thomas Chittenden Health Center.

I consent to allow Thomas Chittenden Health Center to access and share my protected health information for treatment activities of another health care provider.

I consent to allow Thomas Chittenden Health Center to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Thomas Chittenden Health Center to access and share my protected health information to another covered entity for health care operations activities, provided that Thomas Chittenden Health Center and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I consent to the access and sharing of my prescription medical information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program to Thomas Chittenden Health Center for the purpose of my treatment.

AUTHORIZATION

I acknowledge that this consent may be revoked by me at any time, except to the extent that Thomas Chittenden Health Center has already acted in reliance on it. I certify that the information on the previous page is true and correct. I will notify Thomas Chittenden Health Center of any changes in my living or insurance status. I acknowledge I received a copy of Thomas Chittenden's Notice of Privacy Practices and Billing Policy Agreement.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

Thank you for your cooperation in collection of this valuable data.

586 Oak Hill Rd, Williston, VT 05495
Phone (802)878-8131 Fax (802) 879-6853