THE DOOR

The Door – Adolescent Health Center
CLIENT DATA SHEET

Patient Label

Today's Date: _____

Legal Name (please print):

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Preferred name: _____ **Pronouns:** ☐She/Her ☐He/Him ☐They/Them ☐Write in: _____

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security #:** _____

Street Address: _____ **Apt #:** _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Cell Phone #:** _____

It is okay to contact you by (*check all that apply*): ☐ Mail ☐ Call ☐ Text ☐ Email ☐ Portal

Race (*check all that apply*): ☐ Black ☐ White ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other, write in: _____

Ethnicity:
☐ Hispanic/Latino
☐Non-Hispanic/Non-Latino

What language(s) do you speak at home?
☐ English ☐ Spanish ☐ French ☐ Other, write in: _____

Sex at Birth:
☐ Female
☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer, neither Male nor Female
☐ Female to Male/Trans Male ☐ Male to Female/ Trans Female
☐ Choose not to disclose ☐ Other: _____

Do you think of yourself as:
☐ Lesbian/Gay ☐ Straight/Heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose ☐ Write in: _____

Emergency Contact:
First & Last Name: _____ **Relationship to you:** _____
Email Address: _____ **Cell Phone #:** _____

Education Info:
Highest Grade/College Completed: _____ **Are you currently:** ☐ Full-Time Student ☐ Part-Time Student ☐ Not a student

Means of Support:
Are you currently working? ☐ No ☐ Yes If yes, name of your Employer: _____
Amount paid: $_____ ☐ Hourly ☐ Bi-weekly ☐ Monthly ☐ Annual Family Size: _____
If you are not working, how do you support yourself: ☐ Public Assistance ☐ Guardians ☐ Other: _____

Insurance Info:
What type of medical coverage do you have? ***Check one***: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ No Coverage
If covered, provide Plan Name: _____ Plan Number: _____
Is it okay to bill? ☐ Yes ☐ No **If you do not have this information, please try to bring it to your next visit**

To the best of my knowledge, the above information is true. I will inform staff of any changes to my information.

Patient Signature: _____ **Date:** _____

TO BE COMPLETED BY STAFF:	☐ Copy of ID received (or on file) ☐ Copy of Insurance Card received (or on file) ☐ Proof of Income received *- or -* ☐ Financial Assistance Form completed	*Staff Initials:* _____ *Date:* _____

Patient Label

THE DOOR

The Door – A Center of Alternatives, Inc.
Adolescent Health Center

FINANCIAL ASSISTANCE FORM

Legal Name - Last Name: _____ First Name: _____

Preferred name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

1. I am employed at: _____
2. Amount Paid: $ _____ ☐ Hourly ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually
3. Number of Hours per Week: _____
4. Family Size (include yourself): _____
5. My family members who reside with me are (list names & relationships): _____

_____

1. I request to receive assistance with respect to paying for medical care for myself.
2. I request for The Door – Adolescent Health Center to assist me in receiving financial assistance available to me to cover the costs for medical care for myself.
3. I understand that this information is strictly confidential and may not be released to anyone outside of The Door – Adolescent Health Center.
4. I certify that all the information contained in this statement is true and correct.

Patient Signature: _____ Date: _____

Note: any person who knowingly misrepresents family size and/or gross family household income, will no longer be eligible for the sliding fee scale discount program.

I hereby acknowledge that the person named above was screened for financial assistance as part of the health center's Sliding Fee Scale Discount Program.

Staff Signature/Title: _____ Date: _____

The Door – A Center of Alternatives, Inc.
Adolescent Health Center

GENERAL CONSENT FORM

Name: _____ **Date of Birth:** _____

I consent to the provision of medical, dental, eye care, nutrition, dermatology, linkage and navigation services and mental health services given to me by the Adolescent Health Center, which may include physical examinations, vaccines, comprehensive evaluations, screenings and testing, diagnoses, and/or treatment.

I understand that I am receiving services on a voluntary basis, and that family planning services are not required in order for me to receive other services offered at the Adolescent Health Center.

I understand that all information will be kept confidential, except as required by law, or a consent is signed by me which allows the health center to release my records. Family participation in the decision to seek family planning services was discussed with me and encouraged.

I understand that the Adolescent Health Center will respect my chosen methods of communication except when it may be necessary to contact me urgently because of a serious healthcare concern.

I acknowledge that I have been given a copy of the Adolescent Health Center's ***"Patient Bill of Rights and Responsibility"*** information.

If 18 years of age or older, I have been offered information on Advance Directives and informed that I may request a copy of the ***"New York State Health Care Proxy"***.

I have read and understand the above information and have been given the opportunity to ask questions. This consent will remain in effect unless and until I cancel it in writing.

Patient Signature: _____ **Date:** _____

Staff Signature/Title: _____ Date: _____

The Door – A Center Of Alternatives, Inc.
Adolescent Health Center

Notice of Privacy Practices

The Adolescent Health Center protects all of your personal information with special safeguards. Only authorized employees who need the information for the performance of their job and service to you can see it. They are trained regularly in the proper handling of your records.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

A full copy of the Notice of Privacy Practices may be obtained at the Reception Desk.

Patient Name (Please Print): _____ **System #:** _____

Patient Signature: _____ **Date:** _____

Revised 2-2024

THE DOOR

The Door – A Center Of Alternatives, Inc.
Adolescent Health Center

HEALTH CARE SERVICES
CAREGIVER CONSENT FORM

Child's Name (First & Last Name): _____ Date of Birth: _____

Any drug allergies? No ☐ Yes ☐ If yes, please specify: _____

Current medication? No ☐ Yes ☐ If yes, please specify: _____

Permission is granted for my child to receive health care services at The Door - Adolescent Health Center for routine medical services, for treatment of illness, and/or in the event of an emergency.

Services may include:

- Primary Care
  - A complete physical exam, including sports, school or camp physicals, basic laboratory testing, diagnostic testing, first aid, prescription medication, vaccinations, sick visit, treatment for injury, psychosocial assessment, mental health services, nutritional counseling, dermatology, and outside referrals as needed.

- Dental Care
  - An oral examination, including general care and cleaning, digital X-rays, fillings, fluoride treatments, sealants, oral health education and instructions, and referrals for follow-up dental care as needed.

- Eye Care
  - A comprehensive eye exam, including diagnosis and treatment, binocular assessment, glaucoma and cataract evaluation, evaluation of eye health to assess for infection or disease, and referrals as needed.
  - Dilation exam - A dilation exam is a procedure in which drops are instilled in each eye to increase the pupil size so that the inside of the eye may be inspected better by the doctor. This procedure is recommended by the doctor in order to perform the most thorough eye health examination possible.

By signing below, I certify that I am the legal parent or caregiver of the child identified above and I am acting within my authority in signing this consent form.

_____ _____
Parent or Caregiver Name (PRINT) Parent or Caregiver Signature Date

_____ _____
Email Address Home Phone Number Mobile Phone Number

Back-up Emergency Contact Info (to be completed by Parent or Caregiver):

_____ _____
Print Name Relationship Contact Phone Number