



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 Write in:

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

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:



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

Patient Label

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:** \_\_\_\_\_



**The Door - Health Services**  
**HIPAA RELEASE OF INFORMATION FORM**  
 Phone Number: (212) 453-0222 | Fax Number: (212) 941-9614

*Patient Label*

**Section 1: Patient Information**

Last name:		First Name:		Today's date: / /	
Address:			Apartment #:		Date of Birth: / /
City:	State:	Zip Code:		Phone number: ( )	

**Section 2: Release Information To**

I hereby authorize **The Door - Health Services, 555 Broome St. New York, NY 10013**, to:

**RELEASE INFORMATION TO**      or       **OBTAIN INFORMATION FROM**  
*(Place and X in the box that indicates if the information is being released or requested)*

Name:	Medical Facility or Organization (include Department):		
Address:			Phone number: ( )
City:	State:	Zip Code:	Fax number: ( )

**Section 3: Reason for Release of Information**

**Reason:** I authorize release of information for the following reason:

**Section 4: Information to be Released**

Release my medical records for the following dates: FROM \_\_\_\_\_ TO \_\_\_\_\_.

Check **YES** or **NO** for each of the following types of records:

<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory Results	<input type="checkbox"/>	<input type="checkbox"/>	Vaccination Information
<input type="checkbox"/>	<input type="checkbox"/>	Treatment Medication	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Information
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

**Section 5: Sensitive Information**

The following categories of information will **NOT** be released from your records without your specific authorization. To authorize release of this information, **sign your complete name** next to the categories of information you want released.

	Patient Signature	Information to be released and Date Range
HIV Related Information		
Mental Health Treatment		
Substance Use & Treatment		

**Section 6: Authorization**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

- This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my signature on the appropriate line section 5 of this form. In the event the health information described above includes any of these types of information, and I signed the line in the Sensitive Information section, I specifically authorize release of such information to the person(s) indicated in section 2.
- With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at (888) 392-3644. This agency is responsible for protecting my rights.
- I have the right to revoke this authorization at any time by writing to The Door. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*\*This authorization expires 12 months from the date it was signed unless otherwise specified in Section 5.\**

Staff Use only	Staff who Received and Reviewed Form	Staff who Processed, and Scanned Form
Date:		
Signature:		