United Community & Family Services, Inc.

CLIENT ID #:

CLIENT INFORMATION

First Name: / Middle Initial:	Last Name:
Address:	Birthdate:
Address:	Social Security #:
City/State/Zipcode:	If none, please check here: ___
Home Phone #:	Marital Status: Single ___ Married ___
Cell Phone #:	Divorced ___ Widowed ___
Work Phone #:	Email Address:
Best phone # to be reached: Home ___ Cell ___ Work ___	
Primary/Preferred Language? ___	**Race** Please Check all that Apply.
Gender: M ___ F ___	Asian ___
Employed? Yes ___ No ___ Retired? Yes ___ No ___	**American Indian or Alaska Native** ___
Employer Name:	Black or African American ___
Are you a full time student? Yes ___ No ___	**Native Hawaiian or Other Pacific Islander** ___
Are you a Veteran? Yes ___ No ___	White ___
Are you Hispanic? Yes ___ No ___	

Responsible Parties if other than Client

Any client under 18 years of age must have at least 1 responsible party.

1)

Name:	Relationship:
Birthdate:	Social Security #:
Address:	Cell Phone #:
City/State/Zipcode:	Work Phone #:
Home Phone #:	

2)

Name:	Relationship:
Birthdate:	Social Security #:
Address:	Cell Phone #:
City/State/Zipcode:	Work Phone #:
Home Phone #:	

Insurance and Payment Information

Who is responsible for payment of services provided?
If different than the client:

Relationship:

Name:	Birthdate:
Address:	Social Security #:
City/State/Zipcode:	Employer name:
Home Phone #:	

Primary Insurance Company:

Insurance ID #:

Secondary Insurance Company:

Insurance ID#:

Emergency Contact Information

Name:	Relationship to client:
Address:	Home Phone #:
City/State/Zipcode:	Cell Phone #:

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Information Necessary for Participation in Sliding Fee Program

Family Size (#): ____ If member of family is pregnant add 1 to family size	Gross Income (Pick One) Per Week $________ Per Month $_________ Per Year $__________
For office use only:	**Slide:** ____ **Proof of Income Rec'd Date:** __________ **Staff Initials:** ____

CLIENT CONSENT:

I authorize treatment for myself or the client as deemed necessary and appropriate by the provider staff at UCFS.

I authorize the release of any health and other information necessary to process the bill for services provided.
I also authorize payment of health benefits to UCFS for services provided.

____ I DO NOT WISH for UCFS to leave messages.

______________________________ ______________________ ______________

Signature of client, parent, legal guardian, or personal representative **Relationship** **DATE**

I consent to the use or disclosure of the client's protected heath information by United Community & Family Services, Inc. (UCFS) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by UCFS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require me to provide specific authorization. I understand that information regarding how UCFS will use and disclose my information can be found in UCFS's Notice of Privacy Practices. I understand that this consent is effective for as long as UCFS maintains my protected health information.

By signing below, I understand and acknowledge the following:

* I have read and understand this consent; and
* I have been offered UCFS's Notice of Privacy Practices currently in effect.

____

Printed Name

______________________________ ______________________ ______________

Signature of client, parent, legal guardian, or personal representative **Relationship** **DATE**

______________________________ ______________

Witness Signature **DATE**

Unable to obtain written consent and acknowledgment of use or disclosure of protected health information.

____ Refused

____ Emergency

Staff Initials: _____

PC: ____ **D:** ____ **BHS:** ____ **BC:** ____ **CLIENT ID #:**