UCFS
United Community & Family Services

2011

Client Information

Last Name:	Middle Initial:	First Name:
Birthdate: / /		Social Security # : If none, Please check here: ☐
Mailing Address:		
Apt:		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
City/State/Zip code:		
Primary Phone # :		**Race** **Please Check all that Apply.**
Secondary Phone # :		Asian ☐
Email Address:		American Indian or Alaska Native ☐
Primary Language: ☐ English ☐ Spanish ☐ Other: ____________________		Black or African American ☐
Gender: ☐ Female ☐ Male		Native Hawaiian ☐
Are you a full time student? ☐ Yes ☐ No		Other Pacific Islander ☐
Are you a Veteran? ☐ Yes ☐ No		White ☐
Are you Hispanic? ☐ Yes ☐ No		Other ☐

Income Information

Family Size (#) : ______ If member of family is pregnant add 1 to family size	Gross Income *before taxes/deductions* (Pick One): Per Week $_________ Per Month $_________ Per Year $_________

Responsible Party if other than Client

Any client under 18 years of age must have a responsible party on file

Name:	Relationship:
Address:	Primary Phone # :
City/State/Zip code:	

Payment Information

Who is responsible for payment of services provided? ☐ Self ☐ Other (Please complete details below)

Relationship:

Name:	Birthdate:
Address:	Social Security # :
City/State/Zip code:	Employer Name:
Home Phone # :	

Insurance Information

Medical / Behavioral Health Insurance Company:

Insurance ID #:

Policy Holder:	Policy Holder Date of Birth:

Are you covered by another Medical / Behavioral Health Policy? ☐ Yes ☐ No

Dental Insurance Company:

Insurance ID #:

Policy Holder:	Policy Holder Date of Birth:

Are you covered by another Dental Policy? ☐ Yes ☐ No

Emergency Contact Information

Name:	Relationship to client:
Address:	Primary Phone # :
City/State/Zip code:	Secondary Phone # :

For Office Use Only

Client ID:

Received by: **Date:**

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 authorize UCFS to speak with the following individuals about treatment received:

Name **Relationship**

Name **Relationship**

HIPAA Consent

I consent to the use or disclosure of the client's protected health 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 details 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 **Relationship**

Signature of client, parent, legal guardian or personal representative **Date**

For Office Use Only

HIPAA Witness Signature **Date**

Unable to obtain written consent and acknowledgement of use or disclosure of protected health information.
Refused _____ Emergency _____

Client ID:

Data Entry by: **Date:**

Scanned by: **Date:**