ANCHOR HEALTH

Anchor Health - Hamden
2200 Whitney Ave, Suite 290
Hamden, CT 06518

Anchor Health - Stamford
30 Myano Lane, Suite 16
Stamford, CT 06902

PATIENT REGISTRATION FORM

Welcome to Anchor Health! Thank you for choosing us for your care. To register, please complete this form. Let us know if you have any questions or if you need help filling it out.

Today's Date: _____

How can we help you? *Please select all that apply.*

☐ Primary Care ☐ Gender & Life-Affirming Medicine *(GLAM)* ☐ HIV Testing ☐ STI Testing ☐ PrEP for HIV Prevention
☐ HIV Care ☐ Behavioral Health ☐ Case Management ☐ Something Else: _____

PLEASE READ: *Our approach at Anchor Health is to create a health care experience where patients of all genders and sexualities get groundbreaking, radically inclusive, sex-positive, and gender-affirming care. Unfortunately, many insurance companies and legal entities require us to record your legal name and sex for insurance and billing documents.* ***When addressing you, we'll always use the name and pronouns that you ask us to.*** *Several of the items in this form help us ensure that we're meeting the needs of the populations we serve, so please be as thorough as possible.*

Last Name:	**First Name:**	**Middle:**
Legal Name: *(if different)*		

In-house case managers are available to help you legally change your name. Ask a member of your care team for more information!

Date of Birth:	*Month:*	*Day:*	*Year:*	**Social Security Number:**

How do you describe your gender? *Please select all that apply.*

☐ Agender ☐ Bigender ☐ Cisgender ☐ Gender nonconforming ☐ Genderfluid ☐ Genderqueer ☐ Man/male
☐ Nonbinary ☐ Transfeminine ☐ Transgender ☐ Transmasculine ☐ Unsure/questioning ☐ Woman/female
☐ Prefer to self-describe: _____ ☐ Decline to answer

What sex were you assigned at birth? ☐ Female ☐ Intersex ☐ Male ☐ Decline to answer

Pronouns: *Please select all that apply.*

☐ He/him/his ☐ She/her/hers ☐ They/them/theirs
☐ Xe/xem/xyrs ☐ Any/all pronouns ☐ No pronouns, use my name
☐ Prefer to self-describe: _____
☐ Decline to answer

Sexual Orientation: *Please select all that apply.*

☐ Asexual ☐ Bisexual ☐ Demisexual ☐ Gay ☐ Lesbian
☐ Pansexual ☐ Queer ☐ Unsure/questioning ☐ Straight
☐ Prefer to self-describe: _____
☐ Decline to answer

Relationship Structure: *Please select all that apply.*

☐ Aromantic ☐ Dating/casual ☐ Monogamous ☐ Open/non-monogamous ☐ Polyamorous ☐ Unsure ☐ Single
☐ Prefer to self-describe: _____ ☐ Decline to answer

RACE, ETHNICITY, AND LANGUAGE

Race or Ethnicity: *Please select all that apply.*

☐ American Indian *or* Alaska Native ☐ Asian *or* Asian American ☐ Black *or* African American ☐ Hispanic, Latina/e/o/x, *or* Spanish origin
☐ Middle Eastern *or* North African ☐ Native Hawaiian *or* Pacific Islander ☐ White ☐ Unknown ☐ Decline to answer

☐ Prefer to self-describe: _____

Please print your specific ethnicities in the space below:

For example, Korean, Mexican American, Navajo Nation, Samoan, Puerto Rican, French, et al.

_____

How well do you speak English? *¿Que tan bien habla usted Español?*

☐ Very well *(muy bien)* ☐ Well *(bien)* ☐ Not well *(no tan bien)* ☐ Not at all *(no lo habla en lo absoluto)*

What language are you most comfortable speaking? *¿Cuál es el lenguaje con el que se siente más cómodo/a/e hablando?*

☐ American Sign Language *(ASL)* ☐ Cantonese ☐ English *(Inglés)* ☐ French *(including Cajun or Patois)* ☐ Haitian Creole ☐ Italian
☐ Mandarin ☐ Polish ☐ Portuguese ☐ Spanish *(Español)*

☐ Other: _____

What language are you most comfortable reading? *¿Cuál es el lenguaje con el que se siente más cómodo/a/e leyendo?*

☐ Braille ☐ Cantonese ☐ English *(Inglés)* ☐ French *(including Cajun or Patois)* ☐ Haitian Creole ☐ Italian
☐ Mandarin ☐ Polish ☐ Portuguese ☐ Spanish *(Español)*

☐ Other: _____

Do you need an interpreter? *¿Usted necesita un intérprete?* ☐ Yes *(sí)* ☐ No

DISABILITY

Are you d/Deaf or do you have serious difficulty hearing? ☐ Yes ☐ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses? ☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ☐ Yes ☐ No

Do you have serious difficulty walking or climbing stairs? ☐ Yes ☐ No

Do you have difficulty dressing or bathing? ☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? ☐ Yes ☐ No

We want to create a space where all patients can fully participate in their health care.
What accommodations, if any, do you need to ensure the environment supports your abilities?

HOUSING, CONTACT, AND EMPLOYMENT INFORMATION

Physical Address:		**Apartment:**
City:	**State:**	**Zip Code:**

Living Situation: *Please select all that apply.*

☐ At risk of being homeless ☐ Homeless ☐ Homeless sometime during the last 12 months ☐ Living in a vehicle ☐ Staying in a shelter

☐ Transitional housing ☐ Residential program *or* halfway house ☐ Living with someone *(not paying rent)* ☐ Stable *(not homeless)*

☐ Other: _____

☐ Decline to answer

Preferred Phone: ☐ Cell ☐ Home ☐ Work	**Can we leave a voicemail?** ☐ Yes ☐ No
Alternate Phone: ☐ Cell ☐ Home ☐ Work	**Can we leave a voicemail?** ☐ Yes ☐ No
Email Address: *(Must be 13 years of age or older.)*	**Don't send marketing emails.** ☐

Employment Status: *Please select all that apply.*

☐ Disabled ☐ Full-time ☐ Not employed ☐ On active military duty ☐ Part-time ☐ Retired ☐ Self-employed ☐ Student

Veteran: ☐ Yes ☐ No

Worker Status: ☐ Migrant worker ☐ Seasonal worker ☐ Neither

How did you first hear about Anchor Health?

☐ Friend *or* family ☐ Word of mouth ☐ Referral ☐ At an event ☐ Search engine ☐ Facebook

☐ Instagram ☐ Twitter ☐ TikTok ☐ YouTube ☐ Other: _____

Patient privacy is of the utmost importance at Anchor Health. We know how essential privacy can be for LGBTQ people to receive safe and adequate health care. We use Epic/MyChart as our electronic health record. This system integrates with Yale New Haven Health System (YNHHS). If you have ever been to a facility in the YNHHS network, there may already be contact information in Epic for you. We will only use the information provided in this form to contact you.

Please use the space below to inform us of any privacy concerns you may have, such as no mail of any kind, no text messages for appointment reminders, etc. Please speak to your health care provider if you have concerns about adding certain information to your medical record, such as gender identity, sexual orientation, diagnosis of gender dysphoria, etc.

EMERGENCY INFORMATION

Emergency Contact Name:
Relationship:
Phone: ☐ Cell ☐ Home ☐ Work ☐ Other: _____

INSURANCE INFORMATION

*If your first visit is **in-person**, please bring your insurance card(s) and photo identification.*
*If your first visit is **telemedicine**, we'll reach out to you for pictures of your card(s).*

Are you insured? ☐ Yes ☐ No	**We offer discounted and/or free services for patients who qualify based on family size and income.** *Are you interested in applying?* ☐ Yes ☐ No ☐ Unsure
In whose name is your insurance? ☐ Self ☐ Other	

If Other:

Name with Insurance Plan/Company:	**Date of Birth:**
Sex with Insurance Plan/Company: ☐ Female ☐ Male	
Relationship to Patient:	
Member ID/Policy Number:	

Primary Insurance:

Name with Insurance Plan/Company:	
Sex with Insurance Plan/Company: ☐ Female ☐ Male	
Carrier Name:	**Group Number:**
Member ID/Policy Number:	

Secondary Insurance:

Name with Insurance Plan/Company:	
Sex with Insurance Plan/Company: ☐ Female ☐ Male	
Carrier Name:	**Group Number:**
Member ID/Policy Number:	

FEEDBACK

Do you have feedback or suggestions on how we can improve this form?
Please use the space below and let us know.

PATIENT MEDICAL INFORMATION

Would you like to receive primary medical care at Anchor Health?

☐ Yes ☐ No ***(if no, please let us know where you go.)***

Name of Clinic, Hospital, or Practice:		
Name of Provider:		
Phone:		
Preferred Pharmacy:		
Address:		
City:	**State:**	**Zip Code:**

Ask a member of your care team about Anchor Health Pharmacy! Our pharmacists are skilled in navigating insurance coverage for gender-affirming medicine, PrEP, HIV and hepatitis treatment, and more. We offer discounted pricing and prescription pickup or delivery.
By filling your prescriptions with us, you are helping to support our mission.

Are there terms that you prefer to use for your body parts? If so, please use the space below and let us know.

CURRENT MEDICATIONS AND ALLERGIES

Please provide as much detail as possible. This information allows your health care provider to prepare for your visit.

Medications:

Please list all current medications, including over-the-counter vitamins, herbs, supplements, home remedies, and anything else. Write "none" if not applicable.

MEDICATION NAME	*STRENGTH/DOSE*	*ROUTE*	*FREQUENCY*	*REASON FOR TAKING*
Example: Ibuprofen	*200 mg*	*Oral*	*Daily*	*Back pain*

CURRENT MEDICATIONS AND ALLERGIES *(Continued)*

Allergies: *Please list all allergic reactions to medicines, foods, and other agents. Write "none" if not applicable.*

ALLERGY	REACTION

REVIEW OF SYSTEMS

Please check the boxes of any symptoms you are currently experiencing.

General

- ☐ Fatigue, tiredness
- ☐ Fever, chills, profuse sweating
- ☐ Poor general health recently
- ☐ Recent change in weight or appetite
- ☐ Other: _____

Eyes

- ☐ Blurred vision, double vision, loss of vision
- ☐ Irritation or pain
- ☐ Recent eye disease, injury, or surgery
- ☐ Other: _____

Ear, Nose, Mouth, and Throat

- ☐ Chronic or recurring sinus problems
- ☐ Chronic or recurring sore throat
- ☐ Chronic or recurring sores in the nose or mouth
- ☐ Ear pain or discharge
- ☐ Hearing loss or ringing in the ears
- ☐ Other: _____

Heart

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Rapid or irregular heartbeat, palpitations
- ☐ Shortness of breath with exertion
- ☐ Other: _____

Respiratory

- ☐ Chronic coughing
- ☐ Chronic wheezing, asthma
- ☐ Shortness of breath
- ☐ Other: _____

Chest

- ☐ Lumps
- ☐ Nipple discharge
- ☐ Swelling
- ☐ Tenderness
- ☐ Other: _____

(Continued on the next page)

REVIEW OF SYSTEMS *(Continued)*

Gastrointestinal

- ☐ Abdominal pain
- ☐ Black and tarry stool
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Other: _____

Pelvic

- ☐ Genital discharge
- ☐ Late periods
- ☐ Painful periods
- ☐ Pelvic pain
- ☐ Problems with erections
- ☐ Problems with orgasms
- ☐ Sexually transmitted infection *(STI)* exposure
- ☐ Other: _____

Renal

- ☐ Discomfort with urination
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Other: _____

Musculoskeletal

- ☐ Chronic foot pain or deformity
- ☐ Chronic neck or back pain
- ☐ Joint pain, stiffness, or swelling
- ☐ Limitation of motion, difficulty walking
- ☐ Muscle pain, weakness, or cramping
- ☐ Other: _____

Skin

- ☐ Chronic or recurring rashes or sores
- ☐ Hair loss, change in nails
- ☐ Suspicious moles or lesions
- ☐ Other: _____

Neurologic

- ☐ Dizziness, lightheadedness
- ☐ Frequent or recurring headaches
- ☐ Loss of sensation or muscle strength
- ☐ Memory loss, confusion
- ☐ Seizures or convulsions
- ☐ Stroke or head injury
- ☐ Tremor
- ☐ Other: _____

Mental Health

- ☐ Anxiety
- ☐ Depression
- ☐ Inability to concentrate
- ☐ Sleep problems
- ☐ Thoughts of self-harm or suicide
- ☐ Other: _____

Endocrine

- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Loss of height
- ☐ Unexplained bone fractures
- ☐ Other: _____

Hematologic/Lymphatic

- ☐ Cronic anemia
- ☐ Easy bleeding
- ☐ Recurring nosebleeds, bleeding gums, bruising
- ☐ Swollen lymph nodes
- ☐ Other: _____

Allergic/Immunologic

- ☐ Hay fever
- ☐ Hepatitis
- ☐ Recurrent infections
- ☐ Recurring hives
- ☐ Tuberculosis
- ☐ Other: _____

MEDICAL AND SURGICAL HISTORY

Please provide as much detail as possible. This information allows your medical provider to prepare for your visit.

Medical History: *Please list any medical problems that you have had. Write "none" if not applicable.*

CONDITION/DIAGNOSIS	*DATE OF DIAGNOSIS*

Surgical History: *Please list all prior surgeries and dates. Write "none" if not applicable.*

SURGERY/PROCEDURE	*DATE OF SURGERY*

PATIENT HEALTH QUESTIONNAIRE

Over the past 2 weeks, how often have the following problems bothered you?

Please circle the number that corresponds with your answer.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient receiving care at Anchor Health Initiative Corp. *("Anchor Health")*, we want you to know your rights and responsibilities.

Patient Rights

As a patient of Anchor Health, you have the right to:

- Considerate and respectful care in a safe, comfortable environment that contributes to a positive self-image and minimizes distractions that interfere with care.
- Personal privacy and confidentiality, as set forth in our Notice of Privacy Practices.
- Be treated with dignity, free from persecution, neglect, exploitation, sexual harassment, or any type of abuse or discrimination based on your race, color, national origin, sex, gender identity or expression, affectional or sexual orientation, age, disability, religion or belief, marital status, veteran status, English language proficiency, HIV status, or any other status protected by law.
- Know the names of health care providers, their qualifications, and their role in your care.
- Treatment by compassionate, skilled, and qualified health care professionals.
- Be informed about and participate in your care and treatment plans.
- Refuse treatment as allowed by law.
- Request and receive medically appropriate and necessary treatment, subject to applicable law and standards of care.
- Proper assessment and management of your pain or discomfort.
- Request an interpreter.
- Access and obtain copies of your medical records, except as provided by law.
- Receive treatment in an environment that is sensitive to your beliefs, values, and culture.
- Be informed of the care you will need after discharge.
- Receive information about and an explanation of your bill.
- Delegate decisions about your care, treatment, or services to another and/or involve family and others in decisions about your care, treatment, and services.
- Express a complaint or grievance, including one related to your privacy rights as set forth in our Notice of Privacy Practices, by contacting ***Anchor Health's Compliance & Privacy Officer***. You can call ***203-903-8308***, fax ***203-599-3927***, email ***compliance@ahicorp.org***, or visit ***anchorhealthct.org***.
- Contact the following agencies if you are not satisfied with the outcome of your grievance:
  - *You can file a provider complaint with the **Connecticut Department of Public Health** by sending a letter to **410 Capitol Ave, MS# 12HSR, Hartford, CT 06134-0308**; calling **860-509-7552**; emailing **dph.pliscomplaints@ct.gov**; or visiting **www.portal.ct.gov/DPH/Practitioner-Licensing--Investigations/PLIS/Reporting-a-Complaint**.*
  - *You can file a complaint relating to your privacy rights with the **U.S. Department of Health and Human Services' Office for Civil Rights** by sending a letter to **200 Independence Ave, S.W., Washington, D.C. 20201**; calling **1-877-696-6775**; or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**.*

Patient Responsibilities and Code of Conduct

As a patient of Anchor Health, you have the responsibility to:

- Respect the confidentiality and privacy of all Anchor Health patients and visitors.
- Keep track of your appointments and arrive on time for them.
- Cancel appointments with at least 24 hours' (to the hour) notice.
- Provide complete and accurate information about your current health complaints, past illnesses and medical history, hospitalizations, medications, allergies, and other matters relating to your health and/or mental health.
- Respect the comfort and safety of Anchor Health patients, visitors, staff, and property by:
  - *Keeping your noise level low, including phone calls.*
  - *Asking for pronouns (e.g., "What pronouns do you use?" or "What pronouns do you use in this space?") and not assuming what pronouns an individual uses.*
  - *Communicating in a professional, respectful, and courteous manner while in Anchor Health or talking to staff, patients, or visitors.*
  - *Not yelling, cursing, or using hate speech while in Anchor Health or talking to staff, patients, and visitors.*
  - *Not making sexual remarks or advances towards staff, patients, or visitors.*
  - *Not harming, using threatening language, or making threatening physical gestures towards staff, patients, or visitors.*
  - *Not wearing excessive perfumes, oils, or other scents while in Anchor Health.*
- Actively participate in your care by:
  - *Working with your provider to decide on and plan your treatment.*
  - *Telling your provider what you need and about your concerns.*
  - *Asking questions if you don't understand something.*
  - *Telling your provider if you are having trouble following your treatment.*
  - *Taking responsibility to follow preventative measures and adopt health-enhancing behaviors.*
- Ensure that Anchor Health has up-to-date contact information for you, including your address, phone number, and email. If you do not keep your contact information current, we might not be able to contact you with important messages about your health.
- Be financially responsible for the services you receive, which includes providing accurate health insurance information, providing proof of income, applying for government-sponsored benefits, and/or applying for flexible payment plans. You agree to pay any copayments, coinsurance, deductibles, and other cost-sharing required by your insurer and any fees for non-covered services. You authorize us to bill your insurer directly and assign to us all reimbursements from, and any legal or administrative claim against, your insurer.
- Not bring, use, sell, or distribute alcoholic beverages or illegal drugs into Anchor Health or enter under the influence of alcohol or illegal drugs.
- Not smoke, vape, or use any tobacco product in Anchor Health.
- Not lie to obtain prescription medications.
- Not sell or distribute medications prescribed for you.
- Not bring weapons inside Anchor Health. If your job requires you to carry a weapon, you must alert the front desk staff and keep your weapon out of sight.
- Not bring pets or non-service animals into Anchor Health.
- Not pet, offer food to, or interact with service animals in any way.
- Call 911 if you are having a medical emergency.
- Comply with all of Anchor Health's policies, procedures, and guidelines. Not doing so may affect your ability to receive services at Anchor Health, up to and including discharge from care.
- Abide by all applicable laws, including the laws of the city and state in which we are located.
- Follow the directions of staff, especially in an emergency.

If you have questions or need help understanding your rights and responsibilities, please contact our ***Compliance & Privacy Officer*** by calling ***203-903-8308***, faxing ***203-599-3927***, emailing ***compliance@ahicorp.org***, or visiting ***anchorhealthct.org***.

PATIENT CONSENT FORM

For you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. Please read and initial below each item prior to your first appointment.

By signing, you are indicating your agreement.

1. Consent for Treatment

I am voluntarily seeking medical care and treatment from Anchor Health Initiative Corp. *("Anchor Health")* and give permission to the medical staff of Anchor Health to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

Initial for Consent for Treatment:

2. Payment Responsibility

I agree to pay Anchor Health for all services. If I do not have medical insurance or Anchor Health does not participate with my insurance, I understand that I am responsible for all charges incurred and I will pay for all services in full at the time of service. If I am insured:

- *I have given Anchor Health the information necessary to determine my eligibility for such insurance coverage.*
- *I authorize Anchor Health to bill my insurer directly. I assign to Anchor Health all insurance reimbursements otherwise payable to me for services and direct my insurer to pay all reimbursements directly to Anchor Health. I will promptly endorse any insurance reimbursement I receive over to Anchor Health.*
- *I assign to Anchor Health any legal or administrative claim, appeal, or other cause of action I may have under my health plan in connection with Anchor Health's services.*
- *I authorize Anchor Health to release my health care information to my insurer for payment purposes.*
- *I am advised that any tests (including blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.*
- *I understand that my insurance may not cover all charges deemed medically necessary by Anchor Health. I understand that I am responsible for paying for all charges that are not covered by my insurance.*
- *I will pay any copayments, coinsurance, and/or deductibles required by my insurer.*
- *I will pay any amount not billed at the time of service within 30 days of Anchor Health's bill.*

Initial for Acceptance of Responsibility:

3. Consent for Certain Disclosures and Uses of Medical Information

I specifically consent to the following uses and disclosures:

- *My medical information may be used and disclosed for treatment, payment, and health care operations (TPO) without my consent, unless I have requested that Anchor Health restrict how it uses or discloses my medical information to carry out TPO and Anchor Health did not refuse my request.*
- *Anchor Health may access and use prescription history data made available to Anchor Health, including prescriptions written by other health care providers, solely for TPO.*
- *If I have not indicated otherwise in writing, Anchor Health may contact me by any means at any address, phone number, or email address I have provided to Anchor Health.*

Initial for Consent for Disclosures and Uses:

4. Patient Rights and Responsibilities

I have received and reviewed a copy of Anchor Health's Patient Rights and Responsibilities and agree to abide by such document.

Initial for Agreement to Rights and Responsibilities:

I have read all items in this Consent or had them explained to me and I understand and agree to its contents.

Name of Patient: *(PRINTED)*	**Date:**
Signature:	
Name of Person Signing: *(PRINTED)*	

If not signed by patient, please check off the basis for your authority to sign this Consent:

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____

APPOINTMENT CANCELLATION, NO-SHOW, AND LATE POLICY

When you schedule an appointment at Anchor Health, we reserve enough time to provide you with high-quality care. Canceling your appointment without adequate notice, or not showing up to it, means that time can't be used to treat another patient in need of care.

As a patient of Anchor Health, you agree to the following policies:

- If you cannot make it to your appointment, you must give our office 24 hours' *(to the hour)* notice. For Monday appointments, that means letting us know the Friday before by your scheduled appointment time.
- If you do not notify our office 24 hours before your appointment that you cannot make it, or you do not show up and do not notify us at all *("no-show")*, **you will be charged a $50 fee, unless you are covered by Connecticut Medicaid *(Husky Health)* or any other insurance that does not permit charges for missed appointments.**
- The fee is charged to the patient, not the insurance company.
- If you no-show for an appointment three or more times, you will not be able to make an appointment for 3 months after the third no-show *(and any existing appointments during the 3 months will be canceled)*, except in medical emergencies or at the discretion of your health care provider.
- If you are a new patient and no-show two or more times for your initial visit, your appointment will not be rescheduled.
- If your provider requires you to complete blood work or laboratory testing before an appointment that you do not complete on time, your appointment will be rescheduled and counted as a no-show. If you are unsure of when to go for blood work/laboratory testing or need additional time to complete this testing, please contact our office for assistance.
- If you are running late for an appointment, please let us know as soon as possible. If you arrive 15 minutes or later than your scheduled appointment time, it will be rescheduled.

If you are unable to keep a scheduled appointment, you can cancel by calling our office during regular business hours at **203-903-8308** or sending us a message through **MyChart**.

The only exceptions to this policy are due to sudden illness, emergencies, or unexpected office closure such as those due to weather. If one of these is the reason for a missed appointment or late notification, please inform a member of your care team. If you have other barriers preventing you from making your appointments, please let us know and we'll connect you with an in-house case manager.

I acknowledge that I received a copy of Anchor Health's Appointment Cancellation, No-Show, and Late Policy and agree to abide by it.

Name of Patient: *(PRINTED)*	**Date:**
Signature:	
Name of Person Signing: *(PRINTED)*	

If not signed by patient, please check off the basis for your authority to sign this Consent:

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed by Anchor Health Initiative Corp. *("Anchor Health")* **and how you can get access to this information.** Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. *You have the right to:*

Obtain an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Your request must be in writing and you can ask us for a request form. Anchor Health or its third-party medical records vendor will provide a copy of your requested health information, usually within 30 days of your request. You will be charged a reasonable, cost-based fee as permitted by law. Information regarding applicable charges will be made available at our offices.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Your request for a correction must be in writing and state the reason for the correction, and you can ask us for a request form. We may say *"no"* to your request, but we will tell you why in writing and explain how to submit a written statement of disagreement to our response, usually within 60 days.

Request confidential communications. You can ask us to contact you in a specific way *(for example, home or office phone)* or to send mail to a different address. Your request must be in writing and you can ask us for a request form. We will say *"yes"* to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations or with your family, close friends and others involved in your care. We are not required to agree to your request, and we may say *"no"* if it would affect your care. However, if you pay for a service or health care item out-of-pocket in full and you ask us not to share that information with your health insurer for purposes of our payment or our operations, we must say *"yes"* unless a law requires us to share that information.

Get a list of those with whom we've shared information. You can ask for a list *(an accounting)* of the times we've shared your health information for up to 6 years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures *(such as any you authorized us to make)* that we are not required to include in an accounting by law. We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy Notice. You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information at the end of this Notice. You can file a complaint with the ***U.S. Department of Health and Human Services' Office for Civil Rights*** by sending a letter to ***200 Independence Ave, S.W., Washington, D.C. 20201***; calling ***1-877-696-6775***; or visiting ***www.hhs.gov/ocr/privacy/hipaa/complaints***.

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. *Tell us what you want us to do, and we will follow your instructions.*

In these cases, you have both the right and choice to tell us to:

- *Share information with your family, close friends, or others involved in your care*
- *Share information in a disaster relief situation*
- *Include your information in a hospital directory (although, we do not maintain such a directory)*

If you are not able to tell us your preference—*for example, if you are unconscious*—we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- *Marketing purposes*
- *Sales of your information*
- *Most sharing of psychotherapy notes*

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this Notice and give you a copy of it. We will not use or share your information other than as described herein unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information regarding HIPAA and your rights, see:
www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Our Uses and Disclosures

We typically use or share your health information in the following ways
(all subject to the Special Rules listed later in this Notice).

Treat you. We can use your health information and share it with other professionals who are treating you.

Examples: *A provider treating you for a medical or mental health issue asks us about related care you receive at Anchor Health or one of our providers has a need to consult with another specialist about your care at Anchor Health.*

Run our organization. We can use and share your health information to run our programs, improve your care, and contact you when necessary.

Examples: *We use health information about you to manage your treatment and services*

Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

Examples: *We give information about you to your health insurance plan so it will pay for the services you receive from Anchor Health.*

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information, see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html*.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Help with public health and safety issues. We can share health information about you for certain situations such as:

- *Preventing disease*
- *Reporting adverse reactions to medications*
- *Assisting with product recalls*
- *Reporting suspected abuse, neglect, or domestic violence*
- *Preventing or reducing a serious threat to anyone's health or safety*

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- *For workers' compensation claims*
- *For law enforcement purposes or with a law enforcement official*
- *With health oversight agencies for activities authorized by law*
- *For special government functions such as military, national security, and presidential protective services*

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Do research. We can use or share your information for health research.

Communications with Business Associates. We can share health information about you with a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of Anchor Health.

Special Rules for Certain Types of Information and Minors

HIV-related information. We may disclose HIV-related information only as permitted or required by Connecticut law. These laws require your consent for most disclosures of HIV-related information, with certain exceptions. For example, your HIV-related protected health information, if any, may be disclosed in the event of a significant exposure to HIV-infection to Anchor Health personnel or to a known partner. Any use and disclosure for such purposes will be to someone able to reduce the outcome of the exposure and limited in accordance with Connecticut and federal law.

Substance use disorder treatment information. The confidentiality of your substance use disorder patient records is protected by federal law and regulations. While we do not provide substance use disorder treatment, we may, in the course of providing services to you, obtain copies of medical records or other information from your substance use disorder treatment provider. In some circumstances, we may be prohibited from further sharing those records or information without your consent. *For more information, see **42 U.S.C. §290dd-2** for the federal statute and **42 C.F.R. Part 2** for federal regulations.*

Minors. We will comply with Connecticut law when using or disclosing protected health information of minors. For example, if you are an unemancipated minor consenting to a health care service related to HIV/AIDS, sexually transmitted diseases, abortion, or alcohol/drug dependence, and you have not requested that another person be treated as a personal representative, you may have the authority to consent to the use and disclosure of your health information.

Contact and Other Important Information

Effective Date; Changes to the Terms of This Notice. *The effective date of this Notice is January 1, 2022.* We can change the terms of this Notice, and the changes will apply to all information we have about you, including information previously created, received, or maintained by us. The new Notice will be available upon request, in each of our offices, and on our website.

Assistance and Further Information. If you have questions or require assistance with exercising any of your rights or choices, please contact our ***Compliance & Privacy Officer*** by calling ***203-903-8308***, faxing ***203-599-3927***, emailing ***compliance@ahicorp.org***, or visiting ***anchorhealthct.org***.

You may also contact our offices for assistance.

Anchor Health - Hamden
2200 Whitney Ave, Suite 290
Hamden, CT 06518

Anchor Health - Stamford
30 Myano Lane, Suite 16
Stamford, CT 06902

Phone: 203-903-8308 *(both locations)*
Fax: 203-599-3927 *(both locations)*

ACKNOWLEDGEMENT

Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for Anchor Health Initiative Corp. ("Anchor Health") or that a copy was made available to me and I had an opportunity to review it. I understand that the Notice of Privacy Practices may be revised from time to time, and I may request a copy of the Notice at any visit.

Name of Patient: *(PRINTED)*	**Date:**
Signature:	
Name of Person Signing: *(PRINTED)*	

If not signed by patient, please check off the basis for your authority to sign this Consent:

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____

Staff Use Only

I tried to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgment. ☐ The individual was unwilling to sign.

☐ A communication barrier prevented us from obtaining acknowledgement. ☐ Other: _____

Name of Staff Member: *(PRINTED)*	**Date:**
Signature:	