I.Client Information

Prefix: ☐Mr. ☐Mrs. ☐Ms. ☐Miss

Last Name:	**First Name:**	**Middle Name**:	**Suffix:** ☐Jr. ☐Sr. ☐II ☐III ☐IV ☐Other

Street Address:

City:	**State**:	**Zip Code**: ___ ___ ___ ___ ___

County of Residence:
☐ Montgomery County ☐ Prince George's County
☐ Other _____

Preferred Contact Phone Number:
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Is that your: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other

Date of Birth: (MM/DD/YYYY):
___ ___ /___ ___ / ___ ___ ___ ___

Age:

Social Security #:
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Gender:
☐ Female ☐ Male ☐ Transgender- identify as male ☐ Transgender- identify as female

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separated ☐ Domestic Partner

Veteran Status:
☐ Veteran ☐ Not Veteran

Country of Origin: ☐ United States ☐ Other: _____

Ethnicity

☐ Not Hispanic

If Hispanic/Latino

☐ Client Declined to Answer

Please specify:

☐ Argentinean
☐ Bolivian
☐ Chilean
☐ Colombian
☐ Cuban
☐ Dominican
☐ Ecuadorian
☐ Guatemalan
☐ Honduran
☐ Mexican
☐ Nicaraguan
☐ Peruvian
☐ Puerto Rican
☐ Salvadoran
☐ Spaniard
☐ Venezuelan
☐ Other Hispanic or Latino

Race: *Please select **all** that apply*

☐ **American Indian or Alaska Native**

If Asian: ***Please specify:***

☐ Asian Indian
☐ Burmese
☐ Bangladeshi
☐ Chinese, except Taiwanese
☐ Filipino
☐ Japanese
☐ Korean
☐ Nepali
☐ Pakistani
☐ Taiwanese
☐ Thai
☐ Vietnamese
☐ Other Asian

☐ **Black or African American**
☐ **Native Hawaiian or Other Pacific Islander**
☐ **White**

☐ **Client Declines to Answer**

Language Preferred: ☐ English ☐ Spanish ☐ Other: _____

Language Assistance (Language Barrier):
☐ Yes ☐ No

Highest Grade Completed:

☐ Less than High School (Last Completed Grade _____)
☐ High School Diploma or GED
☐ At least some college (Associates Degree)
☐ College Graduate (Bachelor's Degree)
☐ Advanced Degree (Master's, PHD, JD & MD)
☐ Client Declines to Answer

II. Income Level

Annual Household Income: **$**_____	**Number of people in the household:** _____

III. Health Insurance Coverage

Type of Insurance:

☐ Medicaid

☐ Private

☐ NO INSURANCE

Medicaid Number / Member ID#:

***If enrolled in a Managed Care, select the provider*:**

☐ Amerigroup ☐ MD Physician Care ☐ Priority Partners ☐ Riverside

☐ United Healthcare ☐ Other: _____

COMPLETE IF YOU HAVE PRIVATE INSURANCE

Name of insurance provider:	**Member ID #:**
	Group #:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PATIENT CONSENT AND FINANCIAL AGREEMENT

_____
Initial

Consent to Testing and Treatment

I consent to the rendering of services from the ***STI Clinic***, and authorize clinic staff to provide such testing, treatment, and/or services as are considered necessary and advisable for me. I understand that such care may include an examination with a review of my medical history, social history, and physical exam including laboratory tests necessary for screening of sexually transmitted infections. I understand that I may receive treatment in the form of injections and other medications that are based on established medical criteria, but not free of risk. I understand that I have the right to refuse any testing, interventions, treatment, services and/or medications at any time to the extent the law allows.

_____
Initial

Financial Agreement

I understand that the *STI Clinic* charges a clinic fee for all services rendered to adults (age 21 and over). I understand that if I have insurance coverage through any Maryland Medicaid insurance provider I will be asked to present my insurance card with a valid picture ID to cover the clinic fee charges. If I fail to provide my Maryland Medicaid information at the time of my appointment or if I do not have Maryland Medicaid benefits, the *STI Clinic* will consider me to be a "**Self-Pay**" patient and I will be responsible to pay the clinic fee charges in full.

I understand that I cannot be turned away or refused services if I cannot pay the required clinic fee. A sliding fee scale for reduced charges is available to "**Self-Pay**" patients. I understand that I will need to provide proof of income to determine whether I am eligible for a reduced clinic fee. I further understand that I will be responsible for paying the fees in full at the time of my appointment and/or I will be billed for any unpaid services at a later date.

_____
Initial

Authorization of Benefits (Maryland Medicaid Only)

I hereby authorize payment of benefits by my Maryland Medicaid insurance provider directly to Montgomery County Maryland Government for all charges in connection with services rendered. I further allow the *STI Clinic* to release relevant parts of my records in the process of seeking reimbursement for services rendered.

By signing below, I certify that I have read, and fully understand, the provisions contained within this document.

Signature:	**Date:**
Print Name:	**Date Of Birth:**