Patient Registration Form

Welcome to Washington Health Institute! We are happy you have chosen us for your care. To register, please complete thisform. Several of the items below help us ensure that we are meeting the needs of the population we serve, so please be as thorough as you can. Let us know if you have any questions or if you need help in completing this

HOW CAN WE HELP YOU?

- ☐ Primary Medical Care
- ☐ HIV Medical Care/Red Carpet
- ☐ HIV Testing
- ☐ STI Testing
- ☐ Post-Exposure Prophylaxis (PEP) *(I believe I was exposed to HIV)*
- ☐ Gender-Affirming Care
- ☐ Pre-Exposure Prophylaxis (PrEP)
- ☐ Substance Abuse Services
- ☐ Support Groups
- ☐ Aesthetics

Wellness services available for existing eligible patients:

- ☐ Acupuncture
- ☐ Diabetes Education
- ☐ Massage Therapy
- ☐ Mental Health Counseling
- ☐ Nutrition
- ☐ Reiki
- ☐ Yoga
- ☐ Smoking Cessation

First Name:		**Middle Initial:**	**Last Name:**		
I go by (Name):					
Date of Birth:	*Month:*	*Day:*	*Year:*	**Social Security Number:**_____–_____–_____	
Street Address:			**Apt. No.:**	**D.C. Ward:**	
City:	**State:**	**Zip:**		*WHI will send you mail to the listed address. We believe it important to communicate with you, and at times, we do mail information.*	
Is your housing: ☐ Stable ☐ Unstable ☐ Temporary					

Phone Numbers:

Cell Number:_____

Home Number:_____

Work Number:_____

Patient Portal:

The most secure way to communicate with us is via our patient portal. Please show us your identification and provide your email address.

Email Address:_____

Gender Identity:

- ☐ Man
- ☐ Woman
- ☐ Trans Man
- ☐ Trans Woman
- ☐ Genderqueer/Non-binary
- ☐ _____

Sex Assigned at Birth:

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ _____

Do you identify as transgender?

☐ Yes ☐ No

Gender Pronouns:

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ _____

Sexual Orientation:

- ☐ Lesbian, Gay, Homosexual
- ☐ Straight, Heterosexual
- ☐ Bisexual
- ☐ _____

Annual Family Income:

$_____

Family Size:

_____

(includes spouse, dependent children, or other people dependent on you)

To comply with Federal law, we are required to collect information about family income and family size from all patients to determine the patient's income by the Federal Poverty Level.

Ethnicity:

- ☐ Non-Hispanic/ Non-Latino

Hispanic/Latino *(please specify)*

- ☐ Mexican Mexican American Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic Latino/a Spanish Origin

Race:

- ☐ African American/Black *(including Africa, Caribbean)*
- ☐ Caucasian/White *(including Middle Eastern)*
- ☐ American Indian or Alaska Native *(including all Original Peoples of the Americas)*

Asian *(please specify)*

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian/Pacific Islander *(please specify)*

- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander

Patient Registration Form (continued)

Language:	**Deaf or hard of hearing:**	**Do you have an advanced health care directive?**
☐ English ☐ Spanish ☐ _____ ☐ I request language translation services.	☐ Yes ☐ No **Preference:** ☐ Live interpreter ☐ Video remote interpreter	☐ Yes *(please bring a copy for your WHI health record)* ☐ No If no, would you like more information? ☐ Yes ☐ No

Emergency Contact Information

First Name:	**Last Name:**		**Relationship:**	
Street Address:	**Apt.:**	**City:**	**State:**	**Zip:**
Cell Number:		**Work Number:**		
Home Number:		**Email Address:**		

Payment and Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.
A list of insurance we accept is available on our website. Our registration staff can also assist you.

Are you insured? ☐ Yes ☐ No	*If you do not have insurance, you may meet with the Insurance Navigators. You may be eligible for insurance or our sliding fee schedule for your services. In order to determine your eligibility, you must provide income, family size, and residency documentation. Until we receive your documentation, you willbe responsible for the full fee for your services.*	
Insurances we do not accept:	*If we do not take your insurance OR you have an HMO, we encourage you to select a provider who takes your insurance. Choosing to get your care with us will mean being charged for the full fee of your care and seeking reimbursement from your insurer.*	
Insurance Information:	**Company:**	**Identification Number:**
	Group Number:	**Contact Number** *(on back of card):*
	In whose name is your insurance? ☐ Self ☐ Spouse Other	**If private/commercial insurance:** ☐ Employer-Paid ☐ Individual-Paid ☐ Other:_____
	Is the responsible party a WHI patient? ☐ Yes ☐ No	
Secondary Insurance Information:	**Company:**	**Identification Number:**
	Contact Number *(on back of card):*	
Sex/Gender Marker with Insurance Company:	WHI recognizes your gender identity. For insurance billing purposes, what sex/gender marker is on file with your insurance company? ☐ Male ☐ Female	Is your legal name on your insurance card? ☐ Yes ☐ No, it's listed as _____

☐ For HIV+ patients: I understand that I may be eligible for savings on my health care if I incur a certain level of health care expenses. For more information, I will call the WHI Billing Department at 202-525-5175.

Acknowledgment of Responsibility for Payment for Services and Assignment of Benefits

- I understand that I am responsible for all charges and fees for my care, except any that might be covered by insurance accepted by WHI.
- I understand that payment, including co-insurance, co-pays and self-pay / sliding fee payments, is due at the time of service.
- For uninsured or underinsured clients: I understand that if my income, family size, or residency changes, I will bring in documentation of those changes to the Benefits and Insurance Navigators. Navigators will re-assess my eligibility for insurance on the sliding fee scale and/or grant-supported care.

Signature:	**Date:**

Give completed form to Reception; fax to 202.450.6088; or mail to 1140 Varnum Street NE, PMB Suite 203, Washington, DC 20017