Heartland Health Center

Embracing people, inspiring health

a nebraska health+ center

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Social Security #: - -
Mailing Address:			Date of Birth: / /
City:	State:	Zip:	Student Status: ❑ Full time ❑ Part time Email Address: _____
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed			Home Phone: Cell Phone:

Gender: ❑ Male ❑ Female ❑ Transgender Male/Female-to-Male ❑ Transgender Female/Male-to-Female ❑ Gender queer ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Lesbian, gay or homosexual ❑ Straight or heterosexual ❑ Bisexual ❑ Something else ❑ Don't know ❑ Choose not to disclose

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian ❑ White ❑ Pacific Islander ❑ Choose not to disclose

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic ❑ Unknown

Homeless Status: ❑ Not Homeless ❑ Doubling Up ❑ Shelter ❑ Street ❑ Transitional

Migrant Worker Status: ❑ Not a Farm Worker ❑ Migrant ❑ Seasonal

Primary Language if Not English: _____ **Do You Need an Interpreter:** ❑ Yes ❑ No

Are you a Veteran? ❑ Yes ❑ No	**Do you smoke?** ❑ Yes ❑ No

EMERGENCY CONTACT

First and Last Name:	Relationship to Patient:	Phone Number: ( )

RESPONSIBLE PARTY- ONLY fill out if Patient is *19 years old or younger or attending school*

Last Name:	First Name:	Middle Initial:	Phone Number: ( )
Date of Birth: / /	Relationship to Patient:	Mailing Address (if different):	

INSURANCE INFORMATION

Do you have Insurance? ❑ Yes ❑ No ***If yes, please provide the receptionist with your insurance card.**

Name of Insurance Company:_____ Copay Amount:_____

Medical/Dental
Please circle type of insurance

Primary Subscriber's Name:_____ Date of Birth:_____/_____/_____

Subscriber's Social Security Number:_____-_____-_____ Relationship to patient:_____

***If you do not have health insurance, would you like to be contacted by a Certified Application Counselor regarding**

1. Access Nebraska/Economic Assistance Programs ❑ Yes ❑ No
2. Medicaid and/or Insurance Market Place for Health Care Coverage ❑ Yes ❑ No

HOUSEHOLD SIZE AND INCOME – *Number of household members (including yourself)*

Name of Persons in Household	Date of Birth	Relationship	Income
		Self	

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Total number of people in my household: _____	My household income is $_____ per ❑ Week ❑ Month ❑ Year

❑I do NOT wish to apply for income based discount fees.

❑I wish to apply for income based discount fees, I will provide complete information about my household income.

Transportation required: ❑ Yes ❑ No

Cost for services is based on a sliding fee discount, if patient qualifies. You are responsible for any other fees which may apply. I understand that the information I am providing in this form is complete and correct to the best of my knowledge. **Initials: _____ Date: _____**

RELEASE OF INFORMATION:

I authorize Heartland Health Center to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. These individuals will be considered by emergency contacts. Without authorization, no information may be shared. I authorized Heartland Health Center to disclose my personal health information with the following people:

Name:	Relationship:	Contact Phone Number:
Name:	Relationship:	Contact Phone Number:

Directions: Please circle the family size and annual household income range (should be in same row)

Family Size	Annual Income Ranges					
1	$0-$12,060	$12,061-$15,075	$15,076-$18,090	$18,091-$21,105	$21,106-$24,120	Over $24,120
2	$0-$16,240	$16,241-$20,300	$20,301-$24,360	$24,361-$28,420	$28,421-$32,480	Over $32,480
3	$0-$20,420	$20,421-$25,525	$25,526-$30,630	$30,631-$35,735	$35,736-$40,840	Over $40,840
4	$0-$24,600	$24,601-$30,750	$30,751-$36,900	$36,901-$43,050	$43,051-$49,200	Over $49,200
5	$0-$28,780	$28,781-$35,975	$35,976-$3,170	$43,171-$50,365	$50,366-$57,560	Over $57,560
6	$0-$32,960	$32,961-$41,200	$41,201-$49,440	$49,441-$57,680	$57,681-$65,920	Over $65,920
7	$0-$37,140	$37,141-$46,425	$46,426-$55,751	$55,171-$64,995	$64,996-$74,280	Over $74,280
8	$0-$41,320	$41,321-$51,650	$51,651-$61,980	$61,981-$72,310	$72,311-$82,640	Over $82,640

PLEASE READ THE FOLLOWING:

My signature below indicates that in accordance with HIPAA, I am aware the Heartland Health Center's Privacy Policy, Patient Rights and Responsibilities, and Financial Policies are available to me upon my request.

My signature indicates that I assign any payment from my insurance carriers to be paid directly to Heartland Health Center. I understand that billing any secondary insurance is my responsibility. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my health care information may be disclosed for information to the insurance companies listed above and their agents for the purpose of obtaining payment for services and determining insurance benefits.

My signature below also gives the staff of the Heartland Health Center, permission to examine and treat myself, my minor child, or my ward_____ within the boundaries of the clinic's provided services.

Patient Name

_____ _____

Signature of Patient or Responsible Party **Date**

For office use only: **Initials: _____Date:_____**

Verified Total Income_____ **Proof of Income Provided: ❑ Yes ❑ No**

Copay Code: 35.00 40.00 45.00 50.00 55.00 Full Fee

Insurance Medicaid Medicare EWM

WeeklyX52 Bi-WeeklyX26 MonthlyX12 AnnuallyX1