

Midtown Health Center

Patient Information

Patient Name: _____ Date: _____
First Middle Last

Race: Native American/Alaskan Native Black/African American Caucasian
 Asian Native Hawaiian Other Pacific Islander more than one race other

Ethnicity: Hispanic or Latino Non-Hispanic Unknown

Marital Status Married Single Widowed Divorced Separated Child

Language: Spanish English Other

Homeless Status: Not Homeless Doubling Up Shelter Street Transitional Treatment Facility
 Incarcerated Public Housing

Veteran Status: Yes No **Worker Status:** Full-Time Part-time Seasonal

Are You a Full or Part-Time Student: Yes No

Gender: Male Female **Sexual Orientation:** Heterosexual Lesbian/Gay Bisexual Transgender

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **Cell:** _____

Address: _____
Street Apartment #
City County State Zip Code

Emergency Contact Info: _____
Name Contact Number

Guarantor/Guardian Information

The following is for: (Check one) the patient's spouse patient's parent / legal guardian if patient is under age of 19

Name: _____
First Middle Last

Male Female Married Single Child Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Cell):** _____ **(Work):** _____ **Ext:** _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: (Check one) the patient patient's parent / legal guardian if patient is under age of 19

Employer Name: _____ **Phone:** _____ **Ext:** _____

Address: _____
Street City State Zip Code

Midtown Health Center

MEDICAL Insurance Information

In order for us to bill your insurance company for services, you MUST provide a copy of your insurance card

Name of POLICYHOLDER: _____
First Middle Last

Is the patient insured? Yes No

POLICYHOLDER'S Birth Date: _____ ID #: _____ Policy # _____ Group # _____

POLICYHOLDER'S Mailing Address: _____
Street City State Zip Code

POLICYHOLDER'S SS#: _____ POLICYHOLDER'S Phone Number: _____

POLICYHOLDER'S Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

DENTAL Insurance Information

In order for us to bill your insurance company for services, you MUST provide a copy of your insurance card

Name of POLICYHOLDER: _____
First Middle Last

Is the patient insured? Yes No

POLICYHOLDER'S Birth Date: _____ ID #: _____ Policy # _____ Group # _____

POLICYHOLDER'S Mailing Address: _____
Street City State Zip Code

POLICYHOLDER'S SS#: _____ POLICYHOLDER'S Phone Number: _____

POLICYHOLDER'S Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Disclaimer

I understand that the information I am providing in this form is complete and correct to the best of my knowledge at this time.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

HIPAA / Consent to Treat

My signature below indicates that in accordance with HIPAA, I am aware of the Midtown Health Center (MHC) / Madison Medical Clinic (MMC) Privacy Policy. Patient Bill of Rights and Financial Policies are available to me online at www.midtownhealthne.org or I may ask an employee of MHC or MMC for a copy of these policies. _____ **Initial**

My signature also gives the staff of MHC/MMC permission to examine and treat myself, or my minor child/ward: _____ within the boundaries of the clinic's provided services.

Name of Patient

I am aware that all services I receive are voluntary and that no patient of MHC/MMC will be required to have services performed against their will.

Signature of Patient or Responsible Party

Date

Midtown Health Center

Release of Information

Should a referral be made by any MHC/MMC provider for my continued care, I authorize disclosure of pertinent medical records. _____ **Initial**

In addition, I authorize the Midtown Health Center/Madison Medical Clinic 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 my emergency contacts. Without authorization, no information may be shared. I authorize the Midtown Health Center/Madison Medical Clinic to disclose my personal health information with the following people:

Name Relationship Phone Number

Name Relationship Phone Number

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Financial (Consent for Service) Assignment of Benefits

My signature below indicates that I assign any payment from my insurance carriers to be paid directly to MHC/MMC. 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 to the insurance companies listed above and their agents for the purpose of obtaining payment for the services and determining insurance benefits.

As a condition of my treatment by MHC/MMC, I understand that insurance co-pays and nominal fees are expected on day of service unless financial arrangements have been made in advance of services. I understand that this practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient.

All dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that the clinic estimates coverage for dental services. The estimated patient portion of the services is expected to be paid on date of service unless prior arrangements are made. I understand that these portions are just estimates and that I am responsible for any difference in the estimated amount.

I give my permission for this facility to release all or part of my medical/dental record to one or more of the following in order to receive prior authorization for services, to meet government regulations, or to assist in my continuing care by a referral provider:

- Local, state or federal Medicaid Office
- My medical/dental insurance carrier
- Hospitals and ambulatory care facilities selected by me
- Nursing home selected by me
- County and state health department
- Other offices of this health center
- Medicare office
- Referral physician selected by me
- Home health agencies selected by me
- School health official for school health program
- Women's, Infant's & Children (WIC) Program
- Social Security Number for the Maternal and Child Health Program

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Midtown Health Center

Household Information

Household
Size

Yearly Income Amount- **Circle the box that represents your household income**

1 →	<i>Below</i> \$11,490	<i>Between</i> \$11,491 - \$17,235	<i>Between</i> \$17,236 - \$22,980	<i>Above</i> \$22,980
2 →	<i>Below</i> \$15,150	<i>Between</i> \$15,151 - \$23,265	<i>Between</i> \$23,266 - \$31,020	<i>Above</i> \$31,020
3 →	<i>Below</i> \$19,530	<i>Between</i> \$19,531 - \$29,295	<i>Between</i> \$29,296 - \$39,060	<i>Above</i> \$39,060
4 →	<i>Below</i> \$23,550	<i>Between</i> \$23,551 - \$35,325	<i>Between</i> \$35,326 - \$47,100	<i>Above</i> \$47,100
5 →	<i>Below</i> \$27,570	<i>Between</i> \$27,571 - \$41,355	<i>Between</i> \$41,356 - \$55,140	<i>Above</i> \$55,140
6 →	<i>Below</i> \$31,590	<i>Between</i> \$31,590 - \$47,385	<i>Between</i> \$47,386 - \$63,180	<i>Above</i> \$63,180
7 →	<i>Below</i> \$35,610	<i>Between</i> \$35,610 - \$53,415	<i>Between</i> \$53,416 - \$71,220	<i>Above</i> \$71,220
8 →	<i>Below</i> \$39,630	<i>Between</i> \$39,630 - \$59,445	<i>Between</i> \$59,446 - \$79,260	<i>Above</i> \$79,260
9 →	<i>Below</i> \$43,650	<i>Between</i> \$43,650 - \$65,475	<i>Between</i> \$65,476 - \$87,300	<i>Above</i> \$87,300

Print Patient Name _____

Patient Signature: _____

PLEASE INCLUDE ANY OF THE FOLLOWING SOURCES OF INCOME:

Wages from Employment

Rents or Royalties

Unemployment Compensation

Income from Estates or Trusts

Workers Compensation

Social Security

Supplemental Security Income

Veteran's Payments

Survivor Benefits

Pension or Retirement Income

Alimony/Child Support

Educational Assistance (do not include student loans)

Monetary Public Assistance (do not include non-cash benefits such as Food Stamps or Housing Subsidies)

Interest or Dividends (excludes capital gains or losses)