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: ☐ *Part-time* ☐ *Full-time* ☐*not a student*

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

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

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

Mailing Address: _____
Street **Apartment #**

_____
City **County** **State** **Zip Code**

_____
e-mail address

Communication Preference: *(select one)* ☐ *Home Phone* ☐*Work Phone* ☐*Mobile Phone* ☐*Email* ☐*Home Address*
☐ *Patient Portal*

Emergency Contact Info: _____
Name Contact Number

Guarantor/Guardian Information

The following is for: ☐ **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
- Medicare office
- My medical/dental insurance carrier
- Referral physician selected by me
- Hospitals and ambulatory care facilities selected by me
- Home health agencies selected by me
- Nursing home selected by me
- School health official for school health program
- County and state health department
- Women's, Infant's & Children (WIC) Program
- Other offices of this health center
- 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 responsible party/guarantor of payment

Midtown Health Center

Household Information

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

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