MIDTOWN HEALTH CENTER

Updated: 5/2026

Section I: Patient Information

Legal Last Name: _____ Legal First Name _____ Middle Initial: _____

Social Security No.: _____ Date of Birth: _____ Sex assigned at birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone No.: _____ Cell Phone No.: _____ Alt. Phone No.: _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Child

Please select one answer per question and provide additional information when required:

Interpreter needed? ☐ Yes ☐ No **Language**: ☐ English ☐ Spanish ☐ Other

Are you a Veteran? ☐ Yes ☐ No **Transportation needed?** ☐ Yes ☐ No

Are you a student? ☐ No ☐ Yes, Full-time ☐ Yes, Part-time

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Please select which of the following best describes your current housing. Please select only one:

☐ Home Owner / Renting ☐ Homeless shelter ☐ Transitional housing ☐ Unknown, choose not to disclose

☐ Living on the streets ☐ Public housing ☐ "Doubling up" with family/friends ☐ Treatment facility / incarcerated

Please select with one of the following best describes your race. Please select only one:

☐ White ☐ Asian Indian ☐ Native Hawaiian ☐ Pacific Islander

☐ Black or African American ☐ American Indian or Native Alaskan ☐ More than one race ☐ Guamanian or Chamorro

☐ Chinese ☐ Filipino ☐ Japanese ☐ Samoan

☐ Vietnamese ☐ Korean ☐ Other Asian ☐ Unknown, not listed or choose not to disclose

Please select with one of the following best describes your ethnicity. Please select only one:

☐ Cuban ☐ Mexican American ☐ Puerto Rican

☐ Chicano ☐ Hispanic ☐ Other

☐ Mexican ☐ Not Hispanic ☐ Choose not to disclose

Emergency Contact / Release of Information

Name: _____ Relationship to Patient: _____

Phone No.: _____ Alt. Phone No.: _____

Is the above contact also approved to receive your health care information? ☐ **Yes** ☐ **No**

Would you like any other individuals to receive your health care information?

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

I authorize Midtown Health Center to disclose my health care information and to discuss my health care needs to those that I above designate. I authorize the release of my billing information and give these individuals the ability to pick up prescriptions and medications on my behalf. These individuals will be considered by emergency contacts. Without authorization, no information may be shared.

Patient Name: _____ **Responsible Party Signature:** _____ **Date:** _____

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Section II: Household Size and Income

Number of individuals in Household:_____ Total Annual Household Income*: $_____ ☐ *I am a Midtown Health Center Employee ☐ I do not wish to apply for a sliding fee scale if eligible for payment discounting.

For reporting purposes, income must be greater than $0. Any income listed as $0 will be modified to the minimum of $1.00

Section III: POLICYHOLDER Insurance Information:

Do you have the following coverage? ☐ **Medical** ☐ **Dental** ☐ **None**

In order to bill your insurance for services, you MUST provide a copy of your insurance card(s).

Medical

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

Policyholder Last Name: _____ First Name: _____ Middle Initial _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address _____

Street City ST Zip Code

Dental

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

POLICYHOLDER Last Name: _____ First Name: _____ Middle Initial: _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address

Street City ST Zip code

Secondary Insurance

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

POLICYHOLDER Last Name: _____ First Name: _____ Middle Initial: _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address _____

Street City ST Zip code

Section IV: Responsible Party

Complete this section if patient is under 19 or if patient is not the financially responsible party

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient _____ Birthdate _____ Social Security No: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

Home Phone No.: _____ Cell No.: _____ Alt. Phone No.: _____

Email: _____ Primary Language _____

Employer: _____

Street City ST Zip Code

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Consent for Diagnosis and Treatment

I voluntarily consent and authorize my attending clinician, their associates, assistants, or other practitioners of Midtown Health Center (MHC) to attend to myself, my minor child, or my ward. I further authorize MHC to deliver clinical services within the boundaries of the clinic's scope including, but not limited to diagnostic procedures, x-rays, administration of medications, and other services as is deemed necessary and advisable.

I recognize that I have the right to refuse any specific diagnostic, consultation, or treatment service without jeopardizing my right to receive other or future services at the center. I understand that I could be asked to sign specific consent for surgical or other special procedures including inhalation analgesia and/or extensive local anesthesia. I am also aware that clinical services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any of the treatment services.

I consent and agree to allow MHC staff to communicate information regarding my appointments, care, and billing via electronic communication in the form of email and/or text messages, but understand I can opt out of these types of communication at anytime.

Additionally, I understand that:
1. In some cases, telehealth services may be available to me. If participating in telehealth services, I will be informed of all people present, and if the appointment is or is not being recorded. I retain the right to exclude anyone from being present. If I decline telehealth services, other alternative options are available to me, including in-person services.
2. All confidentiality protections shall apply to both in-person and telehealth services.
3. I shall have access to all my medical/dental/behavioral health records as provided by law.
4. Information from services provided (images that can be identified as mine or other medical information from either in person or telehealth service) cannot be released to researchers or anyone else without my written consent.

In addition to the above mentioned, my signature below indicates that in accordance with HIPAA, I am aware of MHC's Privacy Policy, Patient Rights and Responsibilities, and Financial Policies, which are available to me upon my request.
I understand that this consent is valid for 1 year and at that time I will be asked for continuing consent.

I have read this document carefully and my questions have been answered to my satisfaction.

Print Name	*Signature (Sign at Clinic)*	*Date*

Financial Consent for Services

This clinic depends upon reimbursement from its patients for the costs incurred for services rendered. As a condition of my treatment, I understand that insurance co-pays and nominal fees are expected on the day of service unless financial arrangements have been made in advance of services.

My signature indicates that I assign payment from my insurance carriers to be paid directly to Midtown Health Center. I understand that I am financially responsible for all charges whether, or not, paid by insurance. I understand that my insurance company will only pay for services it determines are 'reasonable and necessary' and covered under my plan. I agree to provide accurate, up-to-date insurance information at the time of service. If the information provided is inaccurate, incomplete, or if I fail to notify the office of a change in coverage, I understand that I am personally and fully responsible for payment of all services denied by the insurance company as a result.

Dental services performed without previous financial arrangements must be paid in full at the time of service. Patients who carry dental insurance understand that this clinic estimates coverage for dental services. The estimated portion is due at the time of service, and these estimates are subject to change based on insurance coverage. I understand that I am responsible for any difference between the estimated and actual covered amount.

Print Name	*Signature (Sign at Clinic)*	*Date*