HEARTLAND COMMUNITY HEALTH CENTER

346 MAINE ST., SUITE 150
LAWRENCE, KS 66044
PHONE: 785.841.7297
FAX: 785.856.0375
WWW.HEARTLANDHEALTH.ORG

New Patient Registration Form

PATIENT INFORMATION

Last Name (Legal):	First Name (Legal):	MI:	Preferred Name:

Date of Birth:	Social Security #:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Divorced/Separated	Sex Assigned at Birth: ☐ Male ☐ Female

Address:	City:	State:	Zip Code:

Phone #: ☐ permission to leave voice mail	Cell #: ☐ permission to leave voice mail	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student	Employer Name:
Reminder Call Preference: ☐ Phone Call ☐ Text Message			Employer Phone #:

Email Address:

Race: ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White	Gender Identity: *Innermost concept of self as male, female, both, or neither.* ☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Other ☐ Choose to not disclose	Sexual Orientation: *Romantic and/or sexual attraction a person feels for another person.* ☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose to not disclose	Are you homeless? ☐ Yes ☐ No If yes, please select one: ☐ Shelter ☐ Doubling Up ☐ Transitional ☐ Street ☐ Unknown/Other Are you a migrant worker? ☐ Yes ☐ No

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic	Do you have a dentist? If yes, who do you see? ☐ Yes ☐ No Dentist or Dental Practice Name:	Seasonal Employment? ☐ Yes ☐ No
Primary Language Spoken: ☐ English ☐ Spanish ☐ Other (please specify):	Do you have dental insurance? If yes, what insurance is it? ☐ Yes ☐ No ☐ Unknown Dental Insurance Name:	US Veteran? ☐ Yes ☐ No

ADDITIONAL INFORMATION

How did you most likely hear about Heartland?

☐ TV Ad
☐ Radio Ad
☐ Google Search
☐ Online News Source
☐ Print Ad
☐ Mailer
☐ Social Media
☐ Referral by Friend/Family Member
☐ Community Event
☐ Referral by Another Organization (please specify):
☐ Other (please specify):

Are you a registered voter?

☐ Yes ☐ No ☐ I don't know ☐ I would like information on how to become registered

Would you like to subscribe to our eNewsletter?

☐ Yes ☐ No

SPOUSE OR PARENT/GUARDIAN (for minors) INFORMATION

Last Name:	First Name:	Phone #:

*Social Security #:	*Date of Birth:	Employer:

Email:	Employer Phone #:

*Only required for patient/guardian of minor

I hereby state that, to the best of my knowledge, the above information is complete and correct.

Signature: _____ Date: _____

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Emergency and Privacy Contacts

Patient Name:_____ DOB:_____

Emergency Contact(s)

Please list an individual(s) not living with you that we could contact in the case of an emergency.

Name	Relationship to Patient	Phone
1.		
2.		

HIPAA/Privacy Contact(s)

Please list any individual(s) you authorize release of information (verbal and/or written) to that we can communicate with regarding your care. This could include, but is not limited to, physical findings, treatment, laboratory test results, diagnostic test results, and/or medication. This individual may also pick up medications on your behalf.

Name	Relationship to Patient	Phone
1.		
2.		
3.		

I have the right to update the above named individual(s), as needed, by requesting a new Emergency & Privacy Contacts Form from Heartland Community Health Center. In order to update the form, it must be filled out and signed at the clinic and cannot be mailed in or updated verbally. By signing below, I acknowledge and understand the above mentioned statements.

Signature: _____ Date: _____

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Consent and Acknowledgements

CONSENT FOR MEDICAL TREATMENT
I voluntarily consent to and authorize care, encompassing all diagnostic and therapeutic treatments considered necessary or advisable by the health care provider (HCP) including testing for Hepatitis B and C, HIV, and UA's in the event my blood and/or body fluids is suspected to have come in direct contact with any health care worker, to determine if my body fluids have contagious viruses. I understand that all patients will see a HCP and nurse, and that Heartland is a teaching facility in which any cases may be used to instruct pre-med, medical, nursing, or medical assistant students. All student evaluations are under the direct supervision of the attending physician.
Initial Here:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I hereby authorize Heartland to release any information necessary for the course of my treatment. I understand that my records are protected by HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations at any time, except to the extent that action has already been taken in reliance upon it, by given written notice to the provider.
Initial Here:

AUTHORIZATION OF PRESCRIPTION MANAGEMENT
I authorize Heartland to track my medications from all physicians past and present in order to document allergic reactions, adverse side effects, dosages, and other pertinent information to ensure proper treatment and management of my health care.
Initial Here:

NON-COVERED SERVICES & CO-PAYS
As your medical provider, our relationship is with you and not your insurance carrier. We will file your claim to your insurance, however, **you are the sole responsible party for all charges that remain after insurance payments**. You will be responsible for your payment portion at the time of service. Failure to provide Heartland with current, accurate insurance information will result in all charges for services becoming the responsibility of the patient/responsible party. **All co-pays, co-insurance, and deductibles are due at the time the services are performed**. For patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. If we are not contracted with your insurance company, you will be 100% responsible for the payment at the time of service.
Initial Here:

OUTSIDE LAB & X-RAY FEES
If you have labs drawn at Heartland, they will be processed by either Quest or Lawrence Memorial Hospital (LMH). The majority of Heartland's labs are processed by Quest. Labs that cannot be processed by Quest will be sent to LMH. **If your labs are processed by LMH, you will receive a separate bill from LMH** in the mail. If you are uninsured and have labs sent to LMH, please ask for the LMH Financial Assistance Application to apply for reduced LMH fees. The application will need to be mailed or taken to LMH directly. Unfortunately, Heartland has no control over these prices. Our staff can provide you with the application and contact information of the LMH Financial Counselor who can assist you further.
Initial Here:

APPOINTMENT POLICY
Late for Appointment: If you are **10 minutes late** for your appointment, you may have to be rescheduled. Your provider will attempt to work you back into the schedule, but this may be after your scheduled appointment time. If we are unable to work you in, you will have to be rescheduled. If this occurs, this will count as a missed appointment without notice. **No Show or Late Cancel:** If you miss **3** scheduled appointments within a **six-month period of time** without notifying Heartland **at least by the previous business day**, you will be notified via letter that you have been placed on **same-day scheduling**. Each of our providers have appointments that do not become available until 8AM that day. If you are placed on same-day scheduling, please call our office any time after 8AM to be placed in one of these appointments.
Initial Here:

NOTICE OF PRIVACY PRACTICES & CONSUMER BILL OF RIGHTS
Heartland's Notice of Privacy Practices and Consumer Bill of Rights is and was available to read.
Initial Here:

Signature: _____ Date: _____

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Insurance Form

Patient Information

Legal Last Name	Legal First Name	M.I.

Insurance Information

Primary Insurance	Member ID	Group #	Co-pay
Subscriber Name	Date of Birth	Group Name	
Secondary Insurance	Member ID	Group #	Co-pay
Subscriber Name	Date of Birth	Group Name	

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Sliding Fee Scale Discount Application

If you are **uninsured**: Your fees for Heartland services will be based on the information provided here.

If you are **insured**: Based on your income you may qualify for discounted co-pays and other out-of-pocket expenses, if you fill out this application.

Name: _____ Date of Birth: _____

Are you:

- ☐ Insured (You may qualify for discounted co-pays)
- ☐ Uninsured

Are you:

- ☐ Homeless – living in a community shelter
- ☐ Homeless – not living in a shelter
- ☐ Not homeless

Source	Self		Spouse		Other	
	Amount	Frequency (weekly, monthly, etc.)	Amount	Frequency (weekly, monthly, etc.)	Amount	Frequency (weekly, monthly, etc.)
Gross wages, salaries, tips, etc.	$		$		$	
Income from business, self-employment and dependents	$		$		$	
Unemployment compensation, workers' compensation, Social Security, disability income, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income	$		$		$	
Child support, alimony, assistance from outside the household, interest, dividends, rents, royalties, income from estates, trusts, educational assistance or other miscellaneous source	$		$		$	
Total Income	**$**		**$**		**$**	

Total Annual Household Income: $_____

Please report annual income for all household members in detail on table above.

How many people are supported on this income (including yourself)? _____

I understand that if I provide false information, I will be disqualified from the program and all charges will be due in full immediately. I understand that I will be required to submit documentation of proof of income. By signing this form, I certify under penalty of perjury under the laws of the State of Kansas that the information I am providing is true and correct.

Signature: _____ Date: _____

For Office Use Only

Frequency Calculations:

Monthly x 12 Bimonthly (twice per month) x 24

Every two weeks x 26 Weekly x 52

Initials of Heartland Rep: _____ Verified by: _____

Sliding Fee Scale: A B C D E

☐ POI Collected (1 year)

☐ Presumptive Eligibility (30 days)

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Please list out all of your current medications (prescription, over-the-counter, herbal therapies, and supplements):

Medication Name	Dosage	How often?	What time of day?

Female Patients Only:

Are you currently using a form of birth control?

_____ Yes (if yes, please answer the below questions)

_____ No

What method(s) of birth control are you using?

_____ Condoms

_____ Diaphragm

_____ Birth Control Pills

_____ InterUterine Device (IUD)

_____ Depo-Provera

_____ Implanon

_____ Tubal Ligation (tubes tied)

_____ Hysterectomy