



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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/> Divorced/Separated	Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State: Zip Code:
Phone #: <input type="checkbox"/> permission to leave voice mail	Cell #: <input type="checkbox"/> permission to leave voice mail	Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	Employer Name:
Reminder Call Preference: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message			Employer Phone #:
Email Address:			
Race: <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White	Gender Identity: <i>Innermost concept of self as male, female, both, or neither.</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (F to M) <input type="checkbox"/> Transgender Female (M to F) <input type="checkbox"/> Other <input type="checkbox"/> Choose to not disclose	Sexual Orientation: <i>Romantic and/or sexual attraction a person feels for another person.</i> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose to not disclose	Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select one: <input type="checkbox"/> Shelter <input type="checkbox"/> Doubling Up <input type="checkbox"/> Transitional <input type="checkbox"/> Street <input type="checkbox"/> Unknown/Other
		Are you a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic	Do you have a dentist? If yes, who do you see? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist or Dental Practice Name:		Seasonal Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):	Do you have dental insurance? If yes, what insurance is it? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Dental Insurance Name:		US Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No

ADDITIONAL INFORMATION	
How did you most likely hear about Heartland? <input type="checkbox"/> TV Ad <input type="checkbox"/> Social Media <input type="checkbox"/> Radio Ad <input type="checkbox"/> Referral by Friend/Family Member <input type="checkbox"/> Google Search <input type="checkbox"/> Community Event <input type="checkbox"/> Online News Source <input type="checkbox"/> Referral by Another Organization <input type="checkbox"/> Print Ad (please specify): <input type="checkbox"/> Mailer <input type="checkbox"/> Other (please specify):	Are you a registered voter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> I would like information on how to become registered
Would you like to subscribe to our eNewsletter? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<p>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.</p>
Initial Here:
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
<p>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.</p>
Initial Here:
AUTHORIZATION OF PRESCRIPTION MANAGEMENT
<p>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.</p>
Initial Here:
NON-COVERED SERVICES & CO-PAYS
<p>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 <u>Medicare or Medicaid</u>, 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.</p>
Initial Here:
OUTSIDE LAB & X-RAY FEES
<p>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.</p>
Initial Here:
APPOINTMENT POLICY
<p>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.</p> <p>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.</p>
Initial Here:
NOTICE OF PRIVACY PRACTICES & CONSUMER BILL OF RIGHTS
<p>Heartland's Notice of Privacy Practices and Patient Bill of Rights is and was available to read.</p>
Initial Here:

Signature: _____

Date: _____



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Insurance Form

Patient Information

Legal Last Name	Legal First Name	M.I.
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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	
NO 00'S (ZERO'S) ACCEPTED. MUST PROVIDE DOLLAR \$\$ AMOUNTS.	Amount	Frequency <small>(weekly, monthly, etc.)</small>	Amount	Frequency <small>(weekly, monthly, etc.)</small>	Amount	Frequency <small>(weekly, monthly, etc.)</small>
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
- Every two weeks x 26
- Bimonthly (twice per month) x 24
- Weekly x 52

Self-Declare

Sliding Fee Scale: A B C D E

- POI Collected (1 year)
- Presumptive Eligibility (30 days)

Initials of Heartland Rep: _____ Verified by: _____



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Chief Complaint Check-In Screening Form

Name: _____ Date: _____

Preferred Pharmacy: _____

Main reason for today's visit: _____

Other concerns that I would like to discuss if there is time: _____

In the past year, have you had 4 or more alcoholic drinks in one day? Yes No

In the past year, have you used a recreation drug or used prescription drugs that were not prescribed to you? Yes No

Check all that apply:

- I have prescriptions that need to be refilled
- I need a school or work release
- I need the attached form filled out
- I have multiple appointments here today

In the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed or hopeless	0	1	2	3

If you answered "several days" or more to questions 1 or 2, please complete the following:	Not at all	Several Days	More Than Half the Days	Nearly Every Day
3 Trouble Falling asleep, staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or, the opposite: being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

I decline to complete the depression screening tool