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

NEW PATIENT INFORMATION

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

Date of Birth:	Sex Assigned at Birth: □ Male □ Female	Gender Identity: *Innermost concept of self as male, female, both, or neither* □ Male □ Female □ Transgender Male (F to M) □ Transgender Female (M to F) □ Something else: ..... □ Choose not to disclose	Sexual Orientation: *Romantic and/or sexual attraction a person feels for another person.* □ Heterosexual (straight) □ Lesbian or Gay □ Bisexual □ Something Else: ..... □ Don't know □ Choose not to disclose
Home Phone #: □ Permission to leave voicemail	**Cell Phone #:** □ Permission to leave voicemail		
Appointment Confirmation Preference: □ Phone Call □ Text Message *appointments are required to be confirmed through reminder calls/texts*			

Address:	City:	State:	Zip:

Email Address:

*Your email will be used to sign you up for the **patient portal**. This allows you to message your care team, see visit notes, and lab results, etc.*

Social Security #:	Ethnicity: □ Hispanic/Latino □ Not Hispanic	Race: □ Alaska Native □ American Indian □ Asian □ Black / African American □ Native Hawaiian □ Pacific Islander □ White	Are you homeless? □ Yes □ No **If yes, please select one:** □ Shelter □ Street □ Transitional □ Unknown □ Doubling up (couch surfing, etc.) □ Other
Marital Status: □Single □Married □Widowed □ Partner □Divorced □Separated	**Language:** □ English □ Spanish □ Other (please specify):		
Are you a migrant worker? □ Yes □ No	**Are you a U.S. Veteran?** □ Yes □ No	**Would you like to subscribe to our eNewsletter?** □ Yes □ No	

PARENT/GUARDIAN INFORMATION (for minors)

Last Name:	First Name:	MI:

Social Security #:	Phone Number:	Date of Birth:

Email Address:

ADDITIONAL INFORMATION

How did you hear about Heartland?

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

I hereby state, 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.		

□ I decline to provide an emergency contact

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, payment/billing and/or medication. This individual may also pick up medications on your behalf.

Name	Relationship to Patient	Phone
1.		
2.		
3.		

Expiration of HIPAA/Privacy Contacts:

(If nothing checked, it will be assumed that this will be in effect as long as you are a patient or until another contact list replaces this)

□ Specified date: _____
□ On 18th birthday
□ No expiration

□ I wish for this form to replace previous versions; or
□ I wish for those listed to be added to my current contacts

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.

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.

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.

I consent to the statements above.

Signature: _____ **Date:** _____

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.

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.

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 **three** scheduled appointments within a **six-month period of time** without notifying Heartland **at least by the previous business day**, you will be 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.

NOTICE OF PRIVACY PRACTICES & CONSUMER RIGHTS

Heartland's Notice of Privacy Practices and Patient Bill of Rights is and was available to read.

I acknowledge all of the statements above.

Signature: _____ **Date:** _____

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Insurance Form

Patient Information

Legal Last Name:	Legal First Name:	MI:

Medical Insurance Information

Primary Insurance:	Member ID:	Group #	Copay:
Subscriber Name:	Date of Birth:	Group Name:	
Secondary Insurance:	Member ID	Group #	Copay
Subscriber Name:	Date of Birth:	Group Name:	

Dental Insurance Information

Primary Insurance:	Member ID:	Group #
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 may be discounted based on the information provided here.

If you are **insured**: Based on your income you may qualify for discounted copays and other out of pocket expenses. Your out-of-pocket expenses for Heartland services will be based on the information provided here.

Name: _____ Date of Birth: _____

If you do not wish to apply for discounts based on your income, please check the box below.

☐ I decline to apply for the sliding fee scale.

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 (if available). 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

Sliding Fee Scale: A B C D E

Frequency Calculations:

Monthly x 12 Bi-monthly (twice per month) x 24

Every two weeks x 26 Weekly x 52

☐ SELF-DECLARE

☐ POI Collected (1 year)

☐ Presumptive Eligibility (30 days)

Initials of Heartland PSR: _____

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Medication List

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

*If you have brought a printout of your medications from your pharmacy, please give to the nurse with this form.

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

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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