



Benton-Franklin Health District Registration Form

PATIENT NAME: _____ DATE OF BIRTH _____
 LAST FIRST MI (Middle Initial)

ADDRESS _____
 STREET CITY STATE ZIP

PRIMARY PHONE _____ ALTERNATE PHONE _____ PATIENT SOCIAL SECURITY # _____

CIRCLE ONE: SEX: M / F MARITAL STATUS: Married / Single / Divorced / Separated

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

MAILING ADDRESS _____
 (IF DIFFERENT) STREET CITY STATE ZIP

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE: _____ ID # _____ GROUP # _____

BILLING ADDRESS _____ PHONE # _____

INSURED EMPLOYER _____ PHONE # _____

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT _____

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us written request to any of our offices. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

SLIDING FEE DISCOUNT QUALIFICATION

Size of family (Number): _____ Monthly household income: _____ OR Yearly household income: _____

____ **Clients Certification:** I agree that the income information given is true to the best of my knowledge. I understand that to receive a discount, I may be required to provide proof of income in the future, and agree to do so if requested. I also understand that I may not qualify for a discount if I have medical insurance benefits payable for services.

____ I decline to complete the sliding fee schedule and accept full financial responsibility.

____ **Authorization for Minors:** If the patient listed above is a minor, I am the parent or legal guardian. _____ (Print Name).

____ **Assignment of Benefits:** I authorize payment by my insurance directly to Benton-Franklin Health District

____ **Authorization to Release Information:** I authorize release of all information necessary to secure payment of benefits and authorize the use of this signature on all insurance submissions. This includes any information pertaining to the treatment, testing, or counseling of HIV or sexually transmitted diseases.

____ **Financial Responsibility:** I realize I am responsible for my medical expenses. Upon payment or denial from my insurance company, I agree to pay any balance immediately.

____ **Notice of Privacy Practices:** I have been given a Notice of Privacy Practices statement and have had the opportunity to ask any questions regarding it.

____ **Referrals:** I understand that it is my responsibility to obtain any referrals necessary to receive services at the Benton-Franklin Health District.

By my signature I agree to the terms and statements listed above. To my knowledge, all information given is true and correct.

X
 Patient or Legally authorized individual signature DATE TIME

DOB / / YEAR (LAST NAME, FIRST)