LAWRENCE-DOUGLAS COUNTY Health Department

Registration Form

Today's Date: _____ **Time: _____**

REASON FOR VISIT: (*Check all that apply)*

☐Appointment ☐Pregnancy Test ☐Vaginal Infection ☐HIV Test

☐Immunization ☐TB Skin Test/Meds ☐Birth Control Method ☐STD Testing

CLIENT INFORMATION:

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

Age: ____Birth Date: _____ Sex: _____ Email address: _____

Street Address: _____ Apt#/Lot _____

City: _____State: _____ Zip Code: _____

Please check this box if billing information is the same as above ☐

Home Phone: _____ Cell Phone: _____

Cell phone carrier: _____ Is it OK to text? ☐Y or ☐N

ETHNICITY:

☐Hispanic/Latino ☐Non-Hispanic/Latino

RACE: (*Check all that apply)*

☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Black/African-American
☐White ☐Asian ☐Unknown/Not Reported

PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other _____

PARENT/GUARDIAN INFORMATION: (for clients 17 or under)

First Name:_____ Last Name:_____

Birth Date: _____ Relationship to Client_____

OR

☐ I would like to remain confidential from my parent/guardian

Primary Insurance Information (Private, KanCare, Medicaid, Medicare)

Insurance Company: _____ Name of Policyholder: _____

Policyholder's Date of Birth: __/_____/_____ Relationship to Policyholder: _____

Policyholder's SSN: _____ - _____ - _____

Secondary Insurance Information (Private, KanCare, Medicaid, Medicare)

Insurance Company: _____ Name of Policyholder: _____

Policyholder's Date of Birth: __/_____/_____ Relationship to Policyholder: _____

Policyholder's SSN: _____ - _____ - _____

LAWRENCE-DOUGLAS COUNTY
Health Department

Complete the following *Sliding Scale/Income Information* for the following services only: Annual exams, Birth control, STD and some Adult Vaccinations

The Health Department offers a sliding scale to decrease your cost for ***some*** services. This sliding scale is based on household income and size. To most accurately place you on the sliding scale, please provide information regarding income and household size. **If income information is not provided, no sliding scale will be applied, and you will be responsible for all charges**. List yourself and whether you are employed. Income shall include but is not limited to: Wages, salary, commissions, unemployment or workmen's compensation, public assistance money payments, alimony and child support, college and university scholarships, grants, fellowships and assistantships, etc. Income shall not include tax refunds, one-time insurance payments, gifts, loans, and federal non-cash programs such as food stamps, Medicare, or Medicaid.

INCOME INFORMATION			
NAME ALL PERSONS LIVING IN HOME	PLACE OF EMPLOYMENT / SOURCE OF INCOME	**GROSS** INCOME (wages, tips, etc.)	HOW OFTEN PAID (monthly, weekly, etc.)
1. (SELF)		$	
2.		$	
3.		$	
4.		$	
5.		$	
If no income, please check all the reasons that apply: ☐Homeless ☐Student ☐Unemployed ☐Other: _____			
TOTAL GROSS HOUSEHOLD INCOME PER YEAR		**$**	

☐This information is true and correct and I provide it in order to receive reduced fees.
☐I wish to decline income and household size information. I understand I will be responsible for the full fee.

EDUCATION:
☐ < Grade 12 ☐ High School Diploma or GED ☐ Tech or Vocational School Cert/License
☐Some College (no Degree) ☐ Associate's Degree ☐ Bachelor's Degree or higher ☐ Prefer not to respond

Payment Agreement & Authorization for Treatment

I am seeking services voluntarily with the right to defer or decline services and give permission to the Lawrence-Douglas County Health Department to perform the appropriate medical services and testing. Services for one program are not required in order to receive services from other programs. I authorize the health department to bill my health insurance (Private, Medicaid, KanCare, Medicare) and provide information necessary to process claims. I authorize payment of medical benefits to the health department for services provided. I understand I will be responsible for payment for services not paid by my health insurance.
I give permission to share immunization data in the Kansas Immunization Registry for myself and/or minor child(ren), and to sharing immunization data with schools as appropriate. MyResource Connection may share my information between agencies/departments to provide improved delivery of services. LDCHD participates in a health information exchange network (KHIN); you may opt out by contacting http://www.kanhit.org.
Employees of the health department are mandatory reporters if child abuse is suspected.
Clients under 18 years: In event that a life-threatening condition is identified, and I am unwilling or unable to follow-up on referrals, I understand a parent or guardian may be notified.
I acknowledge that a copy of the Lawrence-Douglas County Health Department's "Notice of Privacy Practices" has been made available to me.

_____ _____
Signature of Client or Parent/Guardian **Date**

Updated May 2019