Pacific County Public Health and Human Services Department
Client Registration

Today's Date: _____

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

Date of Birth: _____ Sex: _____ Race: _____ Phone: _____

Mailing Address: _____ _____ _____

Payment Category (To Be Completed by Health Department Staff)

___Insurance ____Medicaid/Medicare ___Take Charge ____Sliding Fee Category

Contact Information

The clinic may need to contact you regarding appointments or to report medical results

May We Contact You by Phone? Yes [ ] No [ ] Mail? Yes [ ] No* [ ]

Do you have anyone else we may contact if we are unable to contact you? Yes [ ] No [ ]
Name_____ Number_____ Relationship_____

If your Answer is No Contact, Please ask the clerk to complete the "Heather Policy" form.

Financial Information

Pacific County Health Department is not a "Free Clinic". Family Planning Services are made available in Pacific County in part by our clients helping to pay for the services they receive.

Average **Monthly** Gross Income: _____ (Include all employment income in household)
(Gross Income= Income before Taxes)

Number of People Living in Household: _____ (People supported by the Monthly Income)

Do you have Private Insurance: Yes_____ No_____

We accept ***Medicaid or Medicare*** payments for services, however if the services you receive are <u>not covered</u> by Medicaid or Medicare, <u>you will be responsible for those charges</u>. (need to fill out "Waiver of Liability" form)

*****COMPLETE IF YOU HAVE APPLIED FOR TAKE CHARGE/PROVIDER ONE MEDICAL*****

What would you like us to do with your ***Take Charge/ProviderOne card*** when it comes to our clinic?

Keep at Clinic _____ Mail it _____ (Initial your choice)

I acknowledge that the information I have given is true and correct to the best of my ability:

X_____ Dated _____

Title X Services will not be denied based on inability to pay

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Statement Regarding Private Insurance:

If you have private insurance that may cover your services that you will be receiving we request that **you** bill your insurance company. We will provide you with a statement that you can send to your insurance company.

The statement we provide for you to submit to your insurance company will show the full cost of the services you receive.

When you receive the Explanation of Benefits (EOB) and/or payment from your insurance company bring the EOB and the payment received to the clinic. We will review your EOB and calculate what you may owe after we receive the money sent to you from your insurance company. The balance that you owe will be assessed based on where you fall on our sliding fee scale minus what was paid by your insurance company.

I acknowledge having read the information on the billing process for private insurance and agree to bill my insurance company for services received at the Pacific County Health Department. I also agree to return to the clinic with the Explanation of Benefits and any monies sent to me by my insurance company. I understand that the amount I am expected to pay will be based on the department's sliding fee scale with any money received from the insurance company deducted from what I owe.

_____ _____

Date Name

I do not wish to bill my private insurance for services received from the Health Department. I understand the Health Department offers services on a sliding fee scale and cannot refuse services based on the inability to pay for those services.

_____ _____

Date Name