



PATIENT INFORMATION

Please Print

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Birthdate _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Work Phone _____ Emergency Contact Phone _____

Sex: Male Female Veteran: Yes No

Relationship to Responsible Party: Self Spouse Child Other _____

Marital Status: Single Married Divorced Separated Widowed

Race: Black American Indian White Other _____

Ethnicity: Latino/Hispanic Other _____

RESPONSIBLE PARTY INFORMATION:

Last Name _____ Middle Initial _____ First Name _____

Social Security Number _____ Birthdate _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Alternate Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Work Phone _____ Family Size _____

Sex: Male Female

Household Income: _____ / Month _____ / Year

Income information is required for our federal grant funding and in no way reflects the way you are charged. Your cooperation is greatly appreciated.

Primary Insurance _____

Secondary Insurance _____

Employer Name _____

Employer Address _____

NON – AREA RESIDENTS WILL BE EXPECTED TO PAY ALL CHARGES IN FULL

I hereby voluntarily consent to medical care encompassing routine diagnostic procedures and medical treatment by the North Woods Community Health Center Medical Staff or the assignee as is necessary in their judgment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the results of treatment examination.

AUTHORIZATION TO RELEASE INFORMATION AND FINANCIAL AGREEMENT

I hereby authorize the release of any information necessary to process my insurance claims. I hereby authorize payment directly to North Woods Community Health Center for professional services rendered to me unless I have previously paid the charges and the insurance company reimburses me. I understand that I am financially responsible for all charges.

You have a right by law (sec.146.83) to inspect your health care records in the presence of an employee at any time during regular business hours upon reasonable notice and to receive a copy of your health records upon payment of reasonable cost.

I acknowledge that I have received the Privacy Practices of North Woods Community Health Center.

Signature _____ Date _____

Continues on next page

North Woods Community Health Center has a sliding fee scale which offers reduced fees to those who qualify.

Are you interested in more information? Yes No

Office Use Only: Information given Date _____ Initials _____

FINANCIAL ARRANGEMENT POLICY

Thank you for choosing North Woods Community Health Center as your health care provider.

We value you as a patient and are proud that you have placed your trust in us.

We will file your insurance for you as a courtesy. Although we will be glad to help where we can, it is your responsibility to resolve any problems with your insurance company. When no insurance coverage exists, you must pay all of the fees. We expect payment every 30 days whether you have insurance or not.

We offer several payment options to meet your needs.

- Pay balance of account with check, cash or money order.
- Pay balance of account with Visa or Master Card.
- Make monthly payments of at least 10% of the initial self-pay balance until the amount is paid in full.
(Not valid on balances under \$100.00)

Other ways to pay:

- We offer the Sliding Fee Scale Program to people unable to pay for services. Acceptance into the program will be decided by household income and family size.
- The clinic will bill Medicare for you. After payment has been received, the amount not allowed by Medicare will be written off. You will be billed for any non-covered services, the co-payment, and any deductible.
- The clinic will bill the Worker's Comp insurance company for you. You must give us the name, address, and phone number of your employer, also the name and address of the company's insurance carrier. You will be personally responsible for your account balance until we receive this information from you.

I have read and understand the Financial Arrangement Policy as above.

Signature _____ Date _____