

Clinical Services Registration Form

LABEL

Welcome to SNHD!

Please complete this form as completely as possible. Let us know if you have questions or need help.

1. What Services Are You Seeking Today? (Check all that apply)

Immunizations Family Health Family Planning Refugee Health Sexual Health Services Tuberculosis (TB) Dental

Last Name First Name Middle Name Social Security Number

DOB Month Day Year Age Female Male Transgender: F to M M to F
 Single Married Divorced Widowed Separated Living Together

Street address Apt/Bldg # City State Zip Code

Main Phone () Work Phone () Alternate Phone ()
 OK to leave message?: Yes No OK to leave message?: Yes No OK to leave message?: Yes No

Race: American Indian or Alaska Native Native Hawaiian/Pacific Islander
 African American/Black Asian Prefer not to answer
 Caucasian/White (inc Hispanic) Other
 Ethnicity: Non Hispanic Hispanic Prefer not to answer

Preferred Method of Contact: Text Phone Mail Email Enter Email Address:

3. Responsible Party Parent(s) or Guardian(s) of Patient

NAME: Relationship: Self Parent/Guardian Spouse/Partner Other
 Check if Address/Phone Same as Above If different, please complete: Phone Number ()
 Street Address City State Zip Code

4. Payment/Insurance Information PLEASE PROVIDE ALL INSURANCE/MEDICAID CARDS AT TIME OF REGISTRATION.

Do you have: Medical insurance? Yes No Medicaid? Yes No Private Insurance? Yes No

Is it ok to bill your insurance? Yes No If no, please explain why:
 Is it ok to mail letters/billing statements to your home address? Yes No
 If no, provide a mailing address/email of your choice.

Primary Insurance Company Insured (Name on the Insurance Card) Relationship to patient: Self Spouse/Partner
 Parent/Guardian Other

Name of Employer Insured's Date of Birth Group Number

Insurance Co. Contact Number (On Back of Card) ID Number

Check if Address/Phone Same as Above If different please complete: Phone Number ()
 Street City State Zip Code

Secondary Insurance Company Insured (Name on the Insurance Card) Relationship to patient: Self Spouse/Partner
 Parent/Guardian Other

Name of Employer Insured's Date of Birth Group Number

Insurance Co. Contact Number (On Back of Card) ID Number

Check if Address/Phone Same as Above If different please complete: Phone Number ()
 Street City State Zip Code

5. Acknowledgement of Responsibility for Payment for Services and Assignment of Benefits

I certify that the above information is correct to the best of my knowledge. I hereby authorize SNHD to furnish the insured's insurance company all information which said insurance company may request concerning the present services rendered. I assign SNHD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I will notify SNHD in writing of any change in my or my minor child's insurance coverage. This authorization shall continue and be in full force and effect until revoked in writing by me. In the event your account becomes past due, a past due account is an account not paid within 30 days from our 1st date of billing you. In the event that you fail to pay in full or make any satisfactory arrangement for payment or otherwise within 60 days of your 1st bill (or we are unable to notify you) your balance could be turned over to our collection agency. A \$25 charge will be assessed to all collection accounts. In addition, you will be responsible for all added percentage based Collection fees/cost per our prevailing collection company contract, attorney fees, court cost, service fees & associated miscellaneous fee/cost.

PRINT NAME: SIGNATURE DATE
 Relationship: Self Parent/Guardian Staff Initials app FLJR 3/2018