Clinical Services Registration Form

LABEL

Southern Nevada Health District
CLINICAL SERVICES

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)

2. Patient/Client Information

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: Check all that apply			**Ethnicity:** Check One	
☐American Indian or Alaska Native	☐Native Hawaiian/Pacific Islander		☐Non Hispanic	
☐African American/Black	☐Asian	☐Prefer not to answer	☐Hispanic	
☐Caucasian/White (inc Hispanic)		☐Other	☐Prefer not to answer	

_____ **(INITIAL) I ACKNOWLEDGE THAT A COPY OF THE "NOTICE OF PRIVACY PRACTICE" HAS BEEN MADE AVAILABLE TO ME.**

_____ **(INITIAL) I AGREE TO RECEIVE TEXT MESSAGES OR EMAIL CORRESPONDENCE FROM SNHD REGARDING VACCINATION REMINDERS AND PARTICIPATION IN FUTURE HEALTH RELATED TOPICS. YOUR INFORMATION WILL REMAIN CONFIDIENTIAL AT ALL TIMES. YOU MAY OPT OUT OF THESE MESSAGES AT ANY TIME.**

3. 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**

4. 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*** _____