PUBLIC HEALTH
Prevent • Promote • Protect
BENTON-FRANKLIN HEALTH DISTRICT

Benton-Franklin Health District Registration Form BFHD Acct#_____

DOB

(LAST NAME, FIRST)

YEAR

Patient's Legal Name (Last name, First name, Middle initial) _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work **Alternate Phone**: _____ ☐ Cell ☐ Home ☐ Work

Date of Birth: _____ **Gender**: ☐ Female ☐ Male ☐ Other **Is Patient a Student?** ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Social Security# _____

Ethnicity *(check one)* **:** ☐ Not of Hispanic origin ☐ Hispanic origin **Primary Language:** _____

Race *(check one)* **:** ☐ White ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander ☐ Other ☐ Patient declines to provide race or ethnicity information

Employment Status: ☐ Employed ☐Unemployed ☐ Retired Retirement Date: _____

Employer Name _____

Responsible Party/Next of Kin _____ **Relationship to Patient**_____

Insurance Information

Primary Insurance _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy # _____ Group # _____

Secondary Insurance _____ Address _____
(Is this a Medicare Supplemental Plan? _____No _____Yes)

City _____ State _____ Zip _____ Phone _____

Policy # _____ Group # _____

Sliding Fee Discount Qualification

Size of family (Number): _____ **Monthly Household Income:** _____ *or* **Yearly Household Income:** _____

_____ **Clients Certification** (initials): I agree that the income information given is true to the best of my knowledge. I understand that to receive a discount, I may be required to provide proof of income in the future, and agree to do so if requested. I also understand that I may not qualify for a discount.

Initial here to decline. ☐ I decline to complete the sliding fee discount qualification and accept full financial responsibility.

Authorization & Signature

_____ **Authorization for Minors:** If the patient listed above is a minor, I am the parent or legal guardian:_____
(Last, First Name)

_____ **Assignment of Benefits:** I authorize payment by my insurance directly to Benton-Franklin Health District.

_____ **Authorization to Release Information:** I authorize release of all information necessary to secure payment of benefits, including information pertaining to the treatment, testing, or counseling of any services including HIV or sexually transmitted diseases

_____ **Financial Responsibility:** I realize I am responsible for my medical expenses. Upon payment or denial from my insurance company, I agree to pay any balance immediately.

_____ **Notice of Privacy Practices:** I have been given a Notice of Privacy Practices statement and have had the opportunity to ask any questions. I understand, as stated in the privacy policy, that Benton-Franklin Health District and my medical or dental providers may mutually exchange health information.

_____ **Referrals:** I accept responsibility for obtaining any referrals needed to receive services at the Benton-Franklin Health District.

By my signature I agree to the terms and statements listed above. To my knowledge, all information given is true and correct.

Patient or Legally Authorized Individuals Signature: _____ **Date:** _____