Heartland Health Center

Embracing people, inspiring health

a nebraska health+ center

Section I: Patient Information

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

Social Security #:_____ Date of Birth:_____ Sex assigned at birth:_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Alt. Phone:_____

Email:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please select one answer per question and provide additional information when required:

Interpreter needed?	☐ Yes	☐ No	Language:_____	
Are you a student?	☐ Yes	☐ No	Student Status?	☐ Full Time ☐ Part Time
Are you a Veteran?	☐ Yes	☐ No		
Are you a migrant farm worker?	☐ Yes	☐ No	☐ Seasonal	
Are you Hispanic, Latino or Chicano?	☐ Yes	☐ No	☐ Choose not to disclose	
Transportation needed?	☐ Yes	☐ No		

Please check which of the following best describes your gender identity:

☐ Male ☐ Transgender male/ female to male ☐ Transgender female/ male to female ☐ Other

☐ Female ☐ Choose not to disclose

Please check which of the following best describes your sexual orientation:

☐ Straight/Heterosexual ☐ Lesbian, gay, or homosexual ☐ Don't know

☐ Bisexual ☐ Something else

Please check which of the following best describes your current housing. Please select only one:

☐ Home Owner/Renting ☐ Homeless Shelter ☐ Transitional Housing ☐ Unknown, choose not to disclose

☐ Living on the streets ☐ Public Housing ☐ "Doubling up" with Family or Friends ☐ Other – Please Specify:

Please check which of the following best describes your race. Please select only one:

☐ White ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander

☐ Black or African American ☐ American Indian or Native Alaskan ☐ More than one race ☐ Unknown, not listed, or choose not to disclose

Emergency Contact / Release of Information

Name:_____ Relationship to Patient:_____

Phone:_____ Alternate phone:_____

Is this contact also approved to receive your healthcare information? ☐ Yes ☐ No

Would you like any other individuals to receive your healthcare information?

Name:_____ Relationship:_____ Contact Phone Number:_____

Name:_____ Relationship:_____ Contact Phone Number:_____

I authorize Heartland Health Center to disclose my health care information and to discuss my health care needs to those that I above designate. I authorize the release of my billing information and give these individuals the ability to pick up prescriptions and medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

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Section II: Household Size and Income

Number of Individuals In Household:_____ Total Annual Household Income: $_____ ☐ I do not wish to report my household size and/or income. ☐ I do not wish to apply for a sliding fee scale if eligible for payment discounting.

Section III: Responsible Party

Complete this section if patient is under 19 or if patient is not the financially responsible party.

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

Relationship to patient:_____ Birthdate:_____ Social Security Number:_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Alt. Phone:_____

Email:_____ Primary Language:_____

Employer:_____ Address:_____ City:_____ State:_____ Zip:_____

Section IV: Referral Information

How did you hear about us?

☐ Physician ☐ School ☐ Hospital ☐ Employee

☐ Work ☐ TV ☐ Radio ☐ WIC

☐ Friend ☐ Social Media ☐ Website ☐ Central Dist. Health Dept.

☐ Third City Comm. Clinic ☐ Other:_____

Section V: Consent to Treat

My signature below indicates that in accordance with HIPAA, I am aware that Heartland Health Center's Privacy Policy, Patient Rights and Responsibilities, and Financial Policies are available to me upon my request.

My signature indicates that I assign any payment from my insurance carriers to be paid directly to Heartland health Center. I understand that billing any secondary insurance is my responsibility. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my health care information may be disclosed for information to the insurance companies listed above and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I voluntarily request consent and authorize my attending provider, their associates, assistants, behavioral health clinician, or other practitioners under their orders to attend to myself, my minor child, or my ward at Heartland Health Center. I further authorize my providers to deliver medical and surgical treatment or HIV testing, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable within the boundaries of the clinic's provided services.

Patient name: _____ Responsible Party Signature: _____ Date: _____

For office use only: **Initials: _____Date:_____**

Verified Total Income_____ **Proof of Income Provided:** ❑ Yes ❑ No

Copay Code: 35.00 40.00 45.00 50.00 55.00 Full Fee

Insurance Medicaid Medicare EWM

WeeklyX52 Bi-WeeklyX26 MonthlyX12 AnnuallyX1