LAWRENCE-DOUGLAS COUNTY
Health Department

Registration Form

Today's Date: _____ **Time:** _____

REASON FOR VISIT: (*Check all that apply)*

☐Appointment ☐Pregnancy Test ☐HIV Test ☐TB Skin Test/Medication

☐Immunization ☐Condoms ☐Birth Control Method ☐STD Testing

CLIENT INFORMATION:

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

Previous name used at the Health Department: _____

Age: ____Birth Date: _____ Sex: _____ Email address: _____

Primary Care Physician: _____

Are you a college Student? ☐**YES** ☐**NO** If so, which university? _____

Street Address: _____ Apt#/Lot _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Is it ok to text? ☐Y or ☐N Cell phone carrier: _____

RACE: (*Check all that apply)*

☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Black/African-American
☐White ☐Asian ☐Unknown/Not Reported

ETHNICITY: ☐Hispanic/Latino ☐Non-Hispanic/Latino

PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other _____

BILL-TO INFORMATION: Please check this box if billing information is the same as above ☐

Person responsible for client's bill: _____ Employer: _____

Address: _____ Phone: _____

_____ Alternate Phone: _____

Primary Insurance Information (Private, KanCare, Medicaid, Medicare)

Insurance Company: _____ Name of Policyholder: _____

Policyholder's Date of Birth: ___/_____/_____ Relationship to Policyholder: _____

Policyholder's SSN: _____ - _____ - _____

Secondary Insurance Information (Private, KanCare, Medicaid, Medicare)

Insurance Company: _____ Name of Policyholder: _____

Policyholder's Date of Birth: ___/_____/_____ Relationship to Policyholder: _____

Policyholder's SSN: _____ - _____ - _____

LAWRENCE-DOUGLAS COUNTY
Health Department

Complete the following *Sliding Scale/Income Information* for the following services only:

Annual exams, Birth control, STD and some Adult Vaccinations

The Health Department offers a sliding scale to decrease your cost for ***some*** services. This sliding scale is based on household income and size. To most accurately place you on the sliding scale, please provide information regarding income and household size. If income information is not provided, no sliding scale will be applied, and you will be responsible for all charges. List yourself, whether or not you are employed. If possible, provide documentation of income such as: current paycheck stub, letter from employer, copy of paycheck, food stamp or AFDC eligibility letter.

INCOME INFORMATION			
NAME ALL PERSONS LIVING IN HOME	PLACE OF EMPLOYMENT / SOURCE OF INCOME	**GROSS** INCOME (wages, tips, etc.)	HOW OFTEN PAID (monthly, weekly, etc.)
1. (SELF)		$	
2.		$	
3.		$	
4.		$	
5.		$	
6.		$	
If no income, please check all the reasons that apply: ☐Homeless ☐Student ☐Unemployed ☐Other: _____			
TOTAL GROSS HOUSEHOLD INCOME PER YEAR		**$**	

☐This information is true and correct and I provide it in order to receive reduced fees. OR

☐I wish to decline income and household size information at this time.

Payment Agreement & Authorization for Treatment

I am seeking services voluntarily with the right to defer or decline services and give permission to the Lawrence-Douglas County Health Department to perform the appropriate medical services and testing. Services for one program are not required in order to receive services from other programs. I authorize the health department to bill my health insurance (Private, Medicaid, KanCare, Medicare) and provide information necessary to process claims. I authorize payment of medical benefits to the health department for services provided. I understand I will be responsible for payment for services not paid by my health insurance.

I give permission to share immunization data in the Kansas Immunization Registry for myself and/or minor child(ren), and to sharing immunization data with schools as appropriate.

Employees of the health department are mandatory reporters if child abuse is suspected.

Clients under 18 years: In event that a life-threatening condition is identified, and I am unwilling or unable to follow-up on referrals, I understand a parent or guardian may be notified.

I acknowledge that a copy of the Lawrence-Douglas County Health Department's "Notice of Privacy Practices" has been made available to me.

_____ _____

Signature of Client or Parent/Guardian **Date**