MARSHALL COUNTY HEALTH DEPARTMENT
CLIENT REGISTRATION FORM

GUARANTOR INFORMATION (*person responsible for payment/billing*)

Name _____ _____ _____ **Gender**_____ **Race**_____
(First) (MI) (Last)

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

DOB ____-____-_____ **Home Phone**_____ **Cell Phone**_____ **SSN#**_____

Listing of Family Members under the age of 18

_____ _____ _____ **DOB**_____ **Gender**_____ **Race**____
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HIPAA WAIVER

Because the Marshall County Health Department is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, your immunizations, health history, prescriptions and any other information contained in your medical records with us.

Please list below any person or agencies that we have your permission to release your information and the information of the above family members to, if requested.

Father_____ **Mother**_____
Spouse_____ **School**_____
Siblings_____ **Daycare**_____
Other_____ **Other** _____

I acknowledge that I have received or have been offered a copy of the Marshall County Health Department's Notice of Privacy Practices with a revision date of February 28, 2016 . I certify that the above information is correct to the best of my knowledge. I understand the GUARANTOR listed above will be responsible for any services provided which insurance does not cover.

IF WE ARE FILING INSURANCE:
Insured or authorized person's signature: I authorize payment of medical benefits to Marshall County Health Department. I also authorize the release of any medical or other information necessary to process this claim.

How many people currently reside in your home?_____

What is your total household income? (yearly)_____ (monthly)_____ (weekly)_____

Authorized Signature _____ **Date**_____

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