

Welcome Hodgeman County Health Department

Patient's Information:

Name _____

Parent _____

Street Address _____

PO Box # _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____

Social Security # _____

Primary Care Physician _____

Insured's Name _____

Insured's Date of Birth _____

Name of Insurance Company _____

Insured's Policy # _____

Insured's Employer _____

Eligibility Status

(Complete by Health Department Staff)

VFC

Medicaid

Healthwave

Alaskan/American Indian Native

No Health Insurance

Under-Insured

Insurance Company does not pay for some or all vaccines

Under-Served

Has a high deductible & is WIC income eligible (show WIC income guidelines - no proof required)

Insured

Insurance pays first dollar or has low deductible

Notice of Privacy Practices:

I acknowledge that I have received a copy of the Hodgeman County Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.

La Afirmación de Haber Recibido El Aviso Sobre Las Prácticas de Privacidad

Yo reconozco que he una copia del aviso sobre las prácticas de privacidad del departamento de salud con fecha de efectividad 14 de abril, 2003.

Authorization for the Hodgeman County Health Department to Bill Insurance:

I authorize the Health Department to bill my medical insurance and will provide the needed insurance documentation to the Health Department.

I authorize the release of medical information necessary to process claims / medical reports. I authorize payment of medical benefits to the Hodgeman County Health Department.

I understand that if for any reason my insurance company does not pay all or part of the medical claim, I will be responsible for paying the bill.

Signature of Client or Guardian
Firma del Paciente/Representante del Paciente

Relationship to Patient
Si la firma es de un representante ¿Cuál es su parentesco con el paciente?

Date assessment taken and employee initials:

Date Fecha

Original to be maintained in Patient's permanent medical record.