Community Health Center of Fort Dodge

Patient Information Sheet

Family	Last	First	MI	Birth date	Sex M-F	Race	Marital Status	Social Security #
Patient								
Spouse or Significant other								
Responsible party if minor								
Children								
Children								
Children								
Other HH member								
Other HH member								

Patient Information:

Address_____ **Telephone (H)** _____ **(W)** _____**Cell** _____

City: _____ **State** _____ **Zip Code**_____ **County** _____

*Person to contact in an emergency **not** living in your household:

Name: _____ Telephone: _____ Relationship: _____

If employed, please let us know where_____ **Full Time□ Part Time□ Self Employed□ Retired □ Unemployed□**

Military Status: **None□ Active□ Retired□ Veteran□** **Student Status:** **None□ Part-time□ Full-time□**

Hispanic/Latino Ethnicity? **Yes □ No □** **Email:** _____

Housing Status (please check one) **Own□ Rent□ Live with friends/family □ Homeless □**

*If you rent do you receive rental assistance (HUD, MIRHA, Shelter plus Care, other)? **Yes □ No □**

Please estimate your income information below. We only collect this information for our federal grant purposes to continue to received funding for those who are uninsured and need our services. Please help us in maintaining our safety net services for those who need medical care. Your name will not be used when reporting for our grant purposes, nor will it be shared with any other entity. Please check your income level according to your household size.

Household Size	Monthly Income Level			
1	< $903 □	< $1353 □	< $1804 □	$1805 + □
2	< $1214 □	< $1820 □	< $2427 □	$2428 + □
3	< $1526 □	< $2288 □	< $3051 □	$3052 + □
4	< $1838 □	< $2755 □	< $3674 □	$3675 + □
5	< $2149 □	< $3223 □	< $4297 □	$4298 + □
6	< $2461 □	< $3690 □	< $4921 □	$4922 + □
7	< $2773 □	< $4158 □	< $5544 □	$5545 + □
8	< $3084 □	< $4625 □	< $6167 □	$6168 + □

DO YOU WISH TO BE EVALUATED FOR A DISCOUNT? YES NO

If yes, please ask for information regarding income verification!

How would you like us to contact you about appointments? Phone Call or Text

How did you hear about us?
□ Television □ Radio □ Newspaper □ Brochure □ Patient/Physician Referral □ Other: _____

Payment Agreement: I hereby certify that the above information is true and that I have reported all sources of income being received to support my family. I agree to promptly and fully pay any charges for services supplied and provided by Community Health Center of Fort Dodge according to the fees established. I agree to promptly pay for charges considered non covered or my responsibility by my insurance companies after the claim has been processed. In the event of non-payment, failure to comply with terms of my payment plan or do not make a payment plan, I will be responsible for any late fees associated with my past due bill. I have read all the above terms and hereby assume responsibility for paying any charges according to these terms.

Assignment of Benefits: I hereby assign and authorize direct payment to Community Health Center of Fort Dodge of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Medical Treatment: I hereby request and give consent for the health care professionals at Community Health Center of Fort Dodge to provide medical treatment to me and/or my family.

Consent to Release Protected Health Information: I authorize Community Health Center of Fort Dodge to release medical information relating to the patient to health insurance companies, health plans or third party payers, or their authorized agents, for the purpose of determining benefits payable in connection in connection with services provided.

_____ _____

Patient or Responsible Party Signature *Date*