KCHC
KENOSHA COMMUNITY HEALTH CENTER, INC.

Date: _____

PATIENT INFORMATION

Legal Last Name | Legal First Name | Middle Initial | Preferred Name

Date of Birth | Social Security Number | Sex at Birth: □ Male □ Female

Home Address | Apt # | City | State | Zip Code

Marital Status: □Single □Married □Divorced □Widowed □Separated □Life Partner □Legally Separated

Is this related to an auto accident or work accident?
□ Auto Accident □ Work Accident
□ Not Applicable

Home Phone | Work Phone | Other Phone □ Cell □ Fax

Email Address | **Pharmacy**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

#1 Relationship to Patient □Self □Spouse □Parent □Other

Last Name | First Name

Date of Birth | Social Security Number | Gender: Male Female

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone | □Cell | □Fax

Employer | Employer Phone

#2 Relationship to Patient □Self □Spouse □Parent □Other

Last Name | First Name

Date of Birth | Social Security Number | Gender: Male Female

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone | □Cell | □Fax

Employer | Employer Phone

INSURANCE INFORMATION

PRIMARY CARRIER: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER: _____ City, State, Zip: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

The U. S. Health Resources and Services Administration requests the following information:

Race: □Black/African American □American Indian/ Alaskan Native Islander □ Asian □ Native Hawaiian □ Other Pacific □White

Gender Identity: □ Female □ Female-to-Male/Transgender Male/Trans Man □Genderqueer, Neither Exclusively Male nor Female
□ Male □ Male-To-Female/Transgender Female/Trans Woman
□ Other, please specify: _____
□ Do Not Wish To Disclose

Sexual Orientation: □Bisexual □Lesbian, Gay or Homosexual □Straight or Heterosexual □ Refused to Report
□ Unknown Other, please specify: _____

Ethnicity: Hispanic/Latino ◯YES ◯NO **Language best served:**

Homeless ◯YES ◯NO **Veteran** ◯YES ◯NO **Agricultural Worker:** ◯YES ◯NO

Number of Household Members: **Total Gross Household Income:** ☐Weekly ☐Annual ☐Monthly

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HOUSEHOLD ASSESSMENT APPLICATION

Patient Name:_____ **Date:** _____

*Please attach copies of: last year's income tax return; paycheck stubs from last two pay periods; last month's unemployment checks; proof of other household income (social security, SSI, child support. alimony, pension, veterans benefits, workers' compensation, public assistance and/or unemployment benefits for all household members). If you are self employed, please submit your most recent year's tax return. Please note: failure to provide complete documentation will result in sliding fee not being applied and patient will be responsible for all charges. **This is a grant requirement & if possible please give us an estimate of what you receive weekly, monthly or annually.**

Are you or any member of your household self-employed? ☐ YES ☐ NO
If yes, please specify type of business and gross income *AND* attach a copy of last year's 1040 Tax Return:

Business:_____ Income: _____

List ALL household members and/or dependents (INCLUDING YOU), their ages, and income:

NAME	DOB	EMPLOYED YES	EMPLOYED NO	GROSS INCOME	PER WEEK MONTH OR YEAR
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		
		◯	◯		

PLEASE LIST OTHER SOURCES OF INCOME:

SOURCE	YES	NO	AMOUNT	PER WEEK, MNTH OR YR
Unemployment Compensation	◯	◯		
Social Security	◯	◯		
Disability Benefits	◯	◯		
Worker's Compensation	◯	◯		
Veterans Benefits	◯	◯		
Alimony	◯	◯		
Child Support	◯	◯		
Other: Pension, Interest, Estate/Trusts etc.	◯	◯		

I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME HAVE BEEN REPORTED. I WILL REPORT ANY INCOME CHANGES AND WILL RE-APPLY EVERY SIX MONTHS EVEN IF NO CHANGES OCCUR. FAILURE TO MEET THESE CONDITIONS MAY DISQUALIFY ME FROM FUTURE KCHC FEE DISCOUNTS.

Signed:_____ Date: _____

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KENOSHA COMMUNITY HEALTH CENTER, INC.

Consent For Treatment

Patient's Name:_____ Birthdate:_____ Patient Account #_____

I give consent and authorize health care services involving evaluation, counseling and recommended treatment by the providers at Kenosha Community Health Center, Inc. I understand that these procedures may include routine diagnostic (testing), radiology (X-rays), laboratory procedures, medication administration, and anesthetic administration.

I have read the consent form, or it has been read to me, and I understand its contents. My questions have been answered to my satisfaction.

_____ _____
Name of Patient (Print) Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative Date

_____ _____
Relationship of Patient's Representative to Patient Name of Representative (Print)

This section is to be completed for children under the age of 18 by only a parent or legal guardian.

I affirm that I am the parent or legal guardian for the above-named minor child. If I am unable to accompany my child, I give permission for the individual(s) named below to accompany my child to his/her treatment appointment(s):
For Patients over 18: I give the individual(s) named below permission to call KCHC regarding scheduling & financial aspects.

Mothers Name: _____ Relationship:_____

Fathers Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____ _____
Signature of Parent, Patient or Legal Guardian Date

06/15 kab **This consent shall be considered in effect until rescinded or revoked.**

KCHC
Kenosha Community Health Center, Inc.

Assignment of Benefits Form

I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical/dental, to issue payment check(s) directly to Kenosha Community Health Center, Inc. for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____	_____
Name of Patient (Print)	Date
_____	_____
Signature of Patient	Date
_____	_____
Signature of Patient's Representative	Date
_____	_____
Relationship of Patient's Representative to Patient	Name of Representative (Print)

☐ I do not have insurance

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the Kenosha Community Health Center, Inc. ("KCHC") Notice of Privacy Practices with information about how KCHC may use and disclose my protected health information (PHI) and about my rights and KCHC's duties under the Health Information Portability and Accountability Act ("HIPAA"). I understand that I may also request additional copies of KCHC's Notice of Privacy Practices if I so desire.

Name of Patient (Print)	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Relationship of Patient's Representative to Patient	Name of Representative (Print)

Document Receipt Sign-Off

By signing this document, I agree that I have received the following documents:

1. Patient Welcome Letter
2. No Show Policy
3. Double Booking Appointment
4. Nondiscrimination Statement
5. After Hours Access
6. Reason for Patient Dismissal

Name of Patient (Print)	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Relationship of Patient's Representative to Patient	Name of Representative (Print)