Heart of Kansas Family Health Care, Inc.
"We Care about your Health"

Patient Demographics/Fill Out Completely

Patients First Name: _____Middle Name: _____Last Name: _____

Preferred Name (If Different) _____Date of Birth: _____/____/____

Social Security Number #: _____ Sex at Birth: M F

Physical Address: _____ PO Box: _____

City: _____ State: _____Zip Code: _____

Phone: (H)_____(Cell)_____(W)_____

Let us help you create your patient portal account! **Email Address:** _____

The Patient Portal: Helps you manage your health anytime, anywhere. Scheduled appointments, send messages, or refill request to us, and view your test results and billing information online without having to schedule an appointment or wait on the phone.

TEXTS: YES / NO **CONSENT TO CALLS: YES / NO** **EMAIL Reminders/Notifications: YES / NO**

Emergency Contact Full Name: _____ Relationship: _____ Phone #: _____

Please Check ALL that Apply in each category.

THESE QUESTIONS AND ANSWERS HELP US WITH OUR GRANT REPORTING AND FUNDING.

Marital Status:	__ Single __ Married __ Divorced __ Separated __ Partner __ Widowed
Language:	__ English __ Spanish __ Interpreter Needed __ Other: _____
Gender Identity:	__ Male __ Female __ Transgender Male (F to M) __ Transgender Female (M to F) __ Other __ Choose not to disclose __ Unknown
Sexual Orientation:	__ Heterosexual __ Lesbian/Gay __ Bi-sexual ___ Other __ Don't know __ Chose not to disclose
Employment:	__ Full-time __ Part-time __ Disabled __ None __ Retired __ Self-employed
Race:	__ African American/Black __ American Indian/Native Alaskan __ White __ Native Hawaiian __ Other Pacific Island __ Chinese __ Vietnamese __ Japanese __ Filipino __ Asian Indian __ Korean __ Guamanian __ Chamorro __ Samoan __ More than one race (mark all) __ Choose Not to Disclose
Ethnicity:	__ Non-Hispanic/Latino __ Hispanic/Latino
Housing Status:	__ In a home __ Homeless __ Transitional __ Shelter __ Public Housing
Agricultural Status:	__ Migrant Worker __ Seasonal Worker __ Dependent of Migrant __ Not an Agricultural Worker __ Dependent of Seasonal
Veteran Status:	__ I have served in the military __ I have NOT serviced in the military.
Student Status:	__ Full-time __ Part-time __ Not in school

Responsible Party Information

☐ **Mark here if same as patient.** **What is the Relationship to the Patient?** _____

Name: _____ SS#_____ Sex: M F

Date of Birth: _____ Phone#_____

Physical Address: _____City: _____State: _____Zip Code: _____

Employer Name: _____Employer Phone#: _____

Patients over the age of 18 are responsible for their own account. (Some Exceptions may apply)

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Please circle the yearly income range before taxes below the number of people in the household:

	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
Under	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	$47,340	$52,720
Between	$15,061 to $22,590	$20,441 to $30,660	$25,821 to $38,730	$31,201 to $46,800	$36,581 to $54,870	$41,961 to $62,940	$47,341 to $71,010	$52,721 to $79,080
Between	$22,591 to $30,120	$30,661 to $40,880	$38,731 to $51,640	$46,801 to $62,400	$54,871 to $73,160	$62,941 to $83,920	$71,011 to $94,680	$79,081 to $105,440
Over	$30,121	$40,881	$51,641	$62,401	$73,161	$83,921	$94,681	$105,441

Additional Information: **Local Pharmacy:** _____ **Mail Order :**_____

Do you have Insurance? YES / NO **Do you Have Medicare? YES / NO** **You may still qualify for a discount!**

Primary -Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Social Security: _____Phone/Cell: _____
Policy #: _____Group #: _____ Relationship to patient: _____

Secondary- Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Social Security: _____ Phone/Cell: _____
Policy #: _____ Group #: _____ Relationship to patient: _____

Complete this section for patients under the age of 18 years: Please do not leave blank.

Mothers Name: _____ Phone/Cell: _____

Fathers Name: _____Phone/Cell: _____

Legal Guardian (must present documentation): _____Phone/Cell: _____

Is patient in Foster Care, Juvenile intake, DCF, SRS, State custody or in another Center? YES / NO

Certification: I certify that the information given in these forms is true and accurate. I have answered the information to the best of my knowledge and ability. I have been given the opportunity to review, fully understand and accept, all terms and policies. This may be verified. All forms are valid for one year and must be updated yearly, even if no changes have occurred.

_____ _____

Patient Signature **Date** **Signature of Parent if Minor** **Date**

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Acknowledgement & Consent

1. Demographic and Responsible Party, I certify that the demographic information, personal information, health insurance, income information. I have provided are true and accurate.

2. Acknowledgement of Receipt of Notice of Privacy Practice. I have received the Notice of Privacy Practice by Heart of Kansas Family Health care Inc today.

3. Assignment of Benefits I authorize the patient's insurance company or third-party payor to pay benefits **for** services provided by Heart of Kansas Family Health Care Inc**. I understand that I am responsible for payment of patient's deductible and any unpaid balance incurred.**

4. I have read and understand the **Financial Policy** for Heart of Kansas Family Health Care Clinic Inc.

5. Disclosure of Information I authorize Heart of Kansas Family Health Care Inc to release medical information required to process my claim and to disclose any patient's protected health information to patient's insurance company needed to determine payment of services rendered to patient.

6. **Consent to Medical Care** I consent to the performance of examination, treatment, laboratory tests, and medical procedures determined to be necessary for the patient's health and welfare by the medical personnel of Heart of Kansas Family Health Care. I acknowledge that Heart of Kansas Family Health Care also provides an integrated care model where behavioral health screenings and consults will be part of the patient care provided.

7. I authorize Heart of Kansas Family Health Care Inc to obtain/have access to my **Medication History**.

8. I authorize Heart of Kansas Family Health Care Inc to obtain/have access to vaccination registry /**Ks Web IZ**.

This authorization expires upon the date of expressed termination of ongoing medical care and treatment by patient by Heart of Kansas Family Health Care Inc and may be revoked at any time by the patient, or their responsible party, by a writing provided to Heart of Kansas, except when disallowed as provided in the notice of Privacy Practices Heart of Kansas may not condition treatment based on the refusal to provide such authorization.

Signature of Patient Date: _____ Date _____

Parent/Legal Guardian: _____ Date: _____

If the patient is minor, I certify that I am the parent legal guardian of this patient and attest to each of the above statements on his/her behalf.