

# HEART CITY HEALTH CENTER REGISTRATION AND FINANCIAL RESPONSIBILITY FORM

Date \_\_\_\_\_ Name of Patient \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Message Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Medicare/Medicaid # \_\_\_\_\_  
 U.S. Citizen \_\_\_\_\_ Are You a Student \_\_\_\_\_ Marital Status \_\_\_\_\_ Highest School Grade Completed \_\_\_\_\_  
 If Patient is under the age of 18: Name of Responsible Parent \_\_\_\_\_  
 Date of Birth of Parent \_\_\_\_\_ Social Security # of Parent \_\_\_\_\_

**Race**

- Asian
- American Indian
- African American
- Other \_\_\_\_\_
- Hispanic / Latino
- Pacific Islander
- Caucasian

**Primary Language**

- English
- French
- German
- Sign Language
- Spanish
- Other \_\_\_\_\_

List all people living in your house (including yourself), their age, and relationship to you:

Name	Age	Relationship	Medicaid Y / N
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Household Monthly Income Falls Between: (Determined by # Living in Household)

- \$903-\$3084 Self-Family
- \$1200 - \$4102 Self-Family
- \$1354-\$4626 Self-Family
- \$1805-\$6168 Self-Family

What Is Your Monthly Income? \_\_\_\_\_

Do you Collect:

- Social Security
- Unemployment
- Any Other Income (rental properties, 2<sup>nd</sup> job, etc.)
- Child Support
- Disability

Do You Live In:

- Public Housing
- Homeless Shelter
- Multiple Family House
- Apartment \_\_\_\_\_ House \_\_\_\_\_

Who Referred you to Heart City Health Center?

- Emergency Room
- Friend
- Self Referral
- Existing Patient
- Healthy Babies
- Women's Care Center
- Faith Mission
- Medicaid
- Social Security
- Outside Physician
- Health Department
- Other \_\_\_\_\_

PLEASE READ THE FOLLOWING STATEMENT AND SIGN IF YOU AGREE:

I CERTIFY UNDER PENALTY OF PERJURY THAT ALL THE INFORMATION I HAVE PROVIDED IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ PFS INITIAL \_\_\_\_\_

If patient is under 18 years of age

\_\_\_\_\_  
Signature of Parent / Guardian

PLEASE REGISTER ½ HOUR PRIOR TO YOUR SCHEDULED APPOINTMENT

Our sliding fee scale (SFS) is based on the Government Poverty Guidelines. You are required to bring in the following income verification prior to your appointment to establish eligibility for the HCHC Sliding Fee Scale:

- Two most recent pay stubs for all members of the family household
- Income tax returns (effective 1<sup>st</sup> 6 months of the following year)
- Alimony
- Child support
- Military pay
- Pension
- VA benefits
- Unemployment
- Student loans
- Workers compensation benefits
- SSI and/or Medicare(see SSI-Medicare Benefit Collection Guidelines)
- Any form of public housing assistance including section 8 (if homeless, we need a letter from your shelter stating you are a resident)
- Any other type of income
- Annuity
- Interest
- Dividends
- Income from rent
- Trustee assistance
- Food stamps
- Cash assistance

Please notify Patient Financial Services when income changes between each appointment. You will be asked to update income verification every 6 months to be eligible for the SFS. Failure to bring the required documentation for your first appointment and every 6 months will result in you paying full price for your appointment.

**Patient Financial Services can assist you in making a payment agreement for a repayment of an outstanding balance incurred when your physician requires additional services to be performed during you appointment (if you have not failed a previous agreement).**

Medicaid/Medicare patients are required to bring their Medicaid/Medicare card. You will be asked to bring in your card at every appointment. Failure to prove current eligibility will result in rescheduling your appointment. Medicare patients are responsible for the 20% of the approved amount that Medicare does not pay. If you have a secondary insurance plan (in addition to Medicare), please provide the Insurance card to us. After Medicare pays, we will be happy to file this for you on your behalf.

**We are not providers for any Commercial Insurance Company, HMO, PPO, Worker's Compensation Plan, or any other Liability Insurance Plan. We will ask for payment in full for your appointment if determined that you are covered by any insurance company except Medicare and Medicaid.**

PLEASE SIGN THE FOLLOWING STATEMENT OF ACKNOWLEDGEMENT:

I have read and understand this Heart City Health Center Registration and Financial Responsibility Form.

Date\_\_\_\_\_ Signature\_\_\_\_\_ PFS Initial\_\_\_\_\_