# Nevada Health Centers, Inc.
# PATIENT DEMOGRAPHICS

(All information is strictly confidential)

| Last Name | First | Middle Initial | Birth Date: / / |
|---|---|---|---|

| Street Address | Apt # | City | State | Zip |
|---|---|---|---|---|
| Mailing Address / P.O. Box | Apt # | City | State | Zip |

Student?: ☐ No ☐ Full Time ☐ Part Time | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner | Veteran: ☐ Yes ☐ No

| Cell Phone Number ( ) | Home Phone Number ( ) | Alternate Phone Number ( ) | Primary Language: ______ Ethnicity: ☐ Hispanic ☐ Non Hispanic |
|---|---|---|---|

E-mail Address:

| Birth Sex: | Gender Identity: | Sexual Orientation: | Preferred Pronoun(s): |
|---|---|---|---|
| ☐ Male | ☐ Male | ☐ Lesbian or gay | ☐ He, Him, His |
| ☐ Female | ☐ Female | ☐ Straight (not lesbian or gay) | ☐ She, Her, Hers |
| Current Gender: | ☐ Transgender Male / Female-to-Male | ☐ Bisexual | ☐ They, Them, Theirs |
| ☐ Male | ☐ Transgender Female / Male-to-Female | ☐ Something else | ☐ Ze, Hir |
| ☐ Female | ☐ Other | ☐ Don't know | ☐ Decline to Answer |
| ☐ Undifferentiated | ☐ Chose not to disclose | ☐ Chose not to disclose | ☐ Other |

Which of the following groups do you feel you belong to? ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ Refused to report

| Emergency Contact (REQUIRED) | Phone ( ) |
|---|---|

**Responsible Party** (Parent, or legal guardian information. If patient is 18 years or older please print the patient's information.)

| Last Name | First | Middle Initial |
|---|---|---|

| Street Address | Apt # | City | State | Zip |
|---|---|---|---|---|
| Mailing Address / P.O. Box | Apt # | City | State | Zip |

Home Phone ( )

Annual Income: (We need this information for statistical purposes)
☐ $24,000 or less ☐ $25,000 to $49,999 ☐ $50,000 to $74,999
☐ $75,000 to $99,999 ☐ $100,000 or more ☐ Refused to report (Initials ________)

| Employer's Name | Employer's Address (street address, city and state) | Phone ( ) |
|---|---|---|

**Medical Insurance**

| 1 - Primary Insurance Company | ID # | Group # | Address |
|---|---|---|---|
| Name of Insured | DOB | Insured's Employer | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other |
| 2 - Secondary Insurance Company | ID # | Group # | Address |
| Name of Insured | DOB | Insured's Employer | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other |

I hereby voluntarily consent to outpatient care with Nevada Health Centers, Inc., encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to NVHC.

______________________________ ______________________
Signature of Patient, Parent or Legal Guardian Date

NEVADA HEALTH CENTERS

# Nevada Health Centers, Inc.
# FINANCIAL AGREEMENT

I authorize the direct payment of any benefits due to me for the services provided by Nevada Health Centers, Inc. be paid directly to Nevada Health Centers, Inc. by my insurance company.

I realize that although Nevada Health Centers, Inc. may be billing my insurance company on my behalf, I am ultimately responsible for the balance on my account.

**Medicare Patients:** I understand that Nevada Health Centers, Inc. accepts assignment with Medicare, however, I am responsible for a 20% copay at the time of service. Nevada Health Centers, Inc. will bill my supplemental insurance, as long as I provide all information necessary to do so. I understand that Medicare only pays for services it considers to be medically necessary and that the case may arise that I request services Medicare will not pay for, I would be responsible for payment in full.

**Medicaid Recipients:** Federal and State statutes require utilization of all other sources before billing Medicaid for medical services. Other sources include private or employer-provided health and accident insurance coverage. I certify under penalty of fraud that I do not have private or employer provided health and accident insurance, as a primary payer, for my dependents or myself. I understand that Medicaid only pays for services that are to treat a medical condition or illness.

**Private Insurance Patients:** I understand that I am responsible for knowing what benefits are covered by my insurance policy. I understand that Nevada Health Centers, Inc. will verify benefits, but does not guarantee any service will be a covered benefit. I understand that if my insurance does not cover any services received, I will be responsible for payment. I understand that my copay is due and payable at the time of service.

**Self Pay Patients:** I understand that it is the policy of Nevada Health Centers, Inc. to collect payment for services at the time of service.

**Third-Party Collection Agency:** If you have not responded to our attempts to reach you about any unpaid balances, we may opt to send your account to a collection agency.

______________________________ ______________________

Patient Signature / Parent (For Minor Patient) Date

______________________________ ______________________

Witness Date