Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS

(All information is strictly confidential)

Last Name:	First Name:	Middle Initial:
Birth Date:	Legal Sex: ☐ Male ☐ Female	
Street Address:		City:
State: ZIP:	County:	Country:
Home Phone:	Work Phone:	Mobile Phone:
E-mail:		

DEMOGRAPHICS

Marital Status: ☐ Married ☐ Domestic Partner ☐ Significant Other ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed ☐ Other

Ethnic Group: ☐ Hispanic, Latino/a, or Spanish Origin ☐ Non-Hispanic or Latino/a ☐ Multiple Hispanic, Latino/a, or Spanish Origins ☐ Mexican/Mexican American, or Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Refused to Report

Which of the following groups do you belong to? ☐ White ☐ Black/African American ☐ American Indian ☐ Alaska Native ☐ Native Hawaiian ☐ Samoan ☐ Filipino ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Korean ☐ Asian Indian ☐ Other Asian ☐ Refused to Report

Homeless Status: ☐ Not Homeless ☐ At Risk for Homelessness ☐ Child at Risk for Homelessness ☐ Currently not Homeless, was in the last 12 months ☐ Homeless Unknown Shelter ☐ Living in Shelter ☐ Living with Others ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel ☐ Street, Camp, Bridge ☐ Transitional Housing ☐ Veteran at Risk for Homelessness ☐ Unknown/Unreported

Migrant (Agricultural) Worker Status: Are you a farmworker? ☐ Yes ☐ No
If yes, please check appropriate box: ☐ Migrant Worker (moves around) ☐ Seasonal Worker (stays in place)

Emergency Contacts

Name:	Relationship:	Primary Phone:
Name:	Relationship:	Primary Phone:
Name:	Relationship:	Primary Phone:

Are you currently employed? ☐ Yes ☐ No	Are you currently an employee of NVHC? ☐ Yes ☐ No

Needs Interpreter: ☐ Yes ☐ No	Preferred Language:

Veteran Status: Are you a veteran? ☐ Yes ☐ No
If yes, please check appropriate box:
☐ Active Duty ☐ Inactive Duty ☐ No previous experience ☐ Reservist ☐ Uncollected

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Responsible Party				
Last Name:		First Name:		Middle Initial:
Birth Date:		Legal Sex: ☐ Male ☐ Female		
Street Address:			City:	
State:	ZIP:	County:	Country:	
Home Phone:		Work Phone:	Mobile Phone:	
E-mail:				
Number of members in household:				

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 ________)

Insurance Information			
Primary Insurance:	Member ID:	Group Number:	Claim Address:
Subscriber Name:	DOB:	Employer:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Secondary Insurance:	Member ID:	Group Number:	Claim Address:
Subscriber Name:	DOB:	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, 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 or Parent/Guardian Signature (for patients under 18) Date

____ ____________________

Witness Signature Date