Check In Sheet – NEMAHA COUNTY COMMUNITY HEALTH SERVICES

Thank you for choosing Nemaha County Community Health Services. In order to serve you, we need the following information. **Please Print.** All information is confidential.

PATIENT INFORMATION			
Patient's First Name: **Patient's Last Name:**		**Birth Date:**	**Age:**
Street Address:		**Phone Number:**	
City:	**County:**	**State:**	**Zip Code:**
Gender: ☐ Male ☐ Female	**Primary Care Physician:**		

INSURANCE INFORMATION			
Insurance Carrier: ☐ KanCare (Aetna, United Healthcare, Sunflower) ☐ Medicare ☐ BCBS ☐ Meritain ☐ SISCO ☐ Aetna ☐ Cigna ☐ United Healthcare ☐ GPHA ☐ Other:_____			
1. Do you have health insurance?			___yes ___no
2. Does your insurance cover immunizations?			___yes ___no
3. Does your insurance cover only select vaccines or cap vaccine costs?			___yes ___no
☐ ***Skip the following section if health insurance copy is attached.***			
Insurance Company:	**Member ID #:**		**Group #:**
Subscriber's Name:	**Relationship to Subscriber:**		**Effective Date:**
Insurance Company Address:	**City:**	**State:**	**Zip Code:**
Name of Employer:	**Work Phone Number:**		
Address of Employer:	**City:**	**State:**	**Zip Code:**

_____I understand that I am financially responsible for all charges for services rendered including the balance remaining after payment of possible insurance benefits. I understand that Nemaha County Community Health Services is not responsible for notifying me in advance of non-covered services and that all non-covered services are my financial responsibility. I understand that if I am unable to pay the full amount due, I must make monthly payments until a zero balance is obtained.

- I certify that the above information is correct to the best of my knowledge.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of immunization records to any school, daycare center, health department or other healthcare provider.
- I acknowledge that I have received a copy of Nemaha County Community Health Services' NOTICE OF PRIVACY PRACTICES with the effective date of September 25, 2013.

_____ _____

Signature of Patient or Parent/Guardian Date