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Nevada Health Centers, Inc

Last Name	First	Middle Initial	Social Security #:	Birthdate: / /	Sex: ☐ F ☐ M

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 | Veteran: ☐ Yes ☐ No

Home Number ( )	Work Number ( )	Alternate ( )	Primary Language: ______ Ethnicity: ☐ Hispanic ☐ Non Hispanic

E-Mail Address: ______________________________

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 ( )

HOW DID YOU HEAR ABOUT US? ☐ FRIEND ☐ FLYER ☐ HOSPITAL__________________ ☐ OTHER________________________

Responsible party (parent, or legal guardian information, if patient is 18 years or older please print the patients' information)

Last Name	First	Middle Initial	Date of birth

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*	How many people live in your home?
Employers Name	Employers Address (Street address, city and state)	Phone ( )

Social Security No.	Date of Birth	Sex ☐ F ☐ M	Marital Status ☐ Single ☐ Married ☐ Divorced

Medical Insurance

1 - **Primary Insurance Company**	ID #	Group #	Address	
Name of Insured	DOB	SS#	Insured's Employer	Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other
2 - **Secondary Insurance Company**	ID #	Group #	Address	
Name of Insured	DOB	SS#	Insured's Employer	Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ 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. 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 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 NVHC, 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 NVHC, Inc. to collect payment for services at the time of service. I understand that paying in full at the time of service will entitle me to a cash pay discount of 15%. To receive the discount your account needs to be current.

Return Check: If your check is returned by the bank unpaid, our office will charge you the amount of your check plus $20.00.

Collection Agency: Any unpaid balances in which the patient is responsible will be turned to a collection agency.

________________________________ ________________
Patient Signature/Parent (For Minor Patient) Date

________________________________ ________________
Witness Date