Family Health Center/Kearny County Hospital

506 Thrope Street
Lakin, Kansas 67860
(620) 355-7550 FAX: (620) 355-7500

521 Main
Deerfield, Kansas 67838
(620) 426-2990 FAX: (620) 426-2991

PATIENT REGISTRATION FORM (Please print all information)

Date: ____________________

Patient Information: (Provide Legal Name)

Name: ____
Last First MI

Date of Birth __________________

Gender: Male _________ Female _________

Marital Status:

________Single
________ Married – Spouse __________________________
________ Other

Mailing Address: ____________________________________

Physical Address: ____________________________________

____
City State Zip Code

Employer: ____________________________________

Address: ____________________________________

____
City State Zip Code

Primary Phone #: ______________________ (Home / Cell / Work)

Secondary Contant #: ____________________ (Home / Cell / Work)

Race: White ☐ Black/African American☐
American Indian/Alaska Native ☐ Asian ☐
Native Hawaiian/other Pacific Islander ☐
Decline ☐ Other ___________________

Ethnicity: Hispanic/Latino___ Not Hispanic/Latino___

Social Security #: ________ - _______ - ________

Language Spoken in Home: English___ Spanish ___ Other___

E-mail for patient portal: ____ ☐ Declined Portal check here

Responsible Party: (If different from patient)

Name: ____
Last First MI

Employer: ____

Address: ____________________________________

____
City State Zip Code

Mailing Address: ____________________________________

Physical Address: ____________________________________

____
City State Zip Code

Work Phone: ____________________________________

Home Phone: ____________________________________

Birth Date: __________________ Race: _______

Social Security #: ________ - _______ - ________

Income & Household Information: Circle your Family/Household Size and Annual Income Column

Family Size	A	B	C	D	E	F
1	$0 - $12140	$12141-$14204	$14205-$16146	$16147-$19303	$19304-$24159	>$24160
2	$0 - $16460	$16461-$19258	$19259-$21892	$21893-$26171	$26172-$32755	>$32756
3	$0 - $20780	$20781-$24313	$24314-$27637	$27638-$33040	$33041-$41352	>$41353
4	$0 - $25100	$25101-$29367	$29368-$33383	$33384-$39909	$39910-$49949	>$49950
5	$0 - $29420	$29421-$34421	$34422-$39129	$39130-$46778	$46779-$58546	>$58547
6	$0 - $33470	$33471-$39160	$39161-$44515	$44516-$53217	$53218-$66605	>$66606
7	$0 - $38070	$38071-$44542	$44543-$50633	$50634-$60531	$60532-$75759	>$75760
8	$0 - $42380	$42381-$49585	$49586-$56365	$56366-$67384	$67385-$84336	>$84337

This information is used for data collection purposes ONLY.

Emergency Contact: (friend or relative not living with you)

Name: ____ Relationship: _____________________________________

Address: ____ Phone: ____

I give Kearny County Hospital and its affiliated entities (FHC/ENT) permission to discuss my health and/or billing information with ____

(list the name of any person(s) with whom you give us permission to speak with.)

Consent for Treatment: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

X_______________
Initial

Insurance/Self Pay Patients: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Kearny County Hospital. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered my third party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

X_______________
Initial

Medicare Patients: I assign payment of authorized Medicare to be made on my behalf to Kearny County Hospital for any services furnished to me. I authorize Kearny County Hospital to release medical information of the Social Security Administration or its intermediaries or carries as required for payment. I agree to pay charges not paid within thirty (30) days after being billed.

X_______________
Initial

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a healthcare worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have Kearny County Hospital determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

CONSENT TO DISPOSAL OF TISSUE/FLUID/SPECIMANS. I agree that the Kearny County Hospital may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of the Joint Notice of Privacy Practices.

X________________
Initial

I certify that I have read and fully understand this document. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

_________________________________	_____________________________	___________________________
Patient/Personal Representative	**Relationship to Patient**	**Date**

_________________________________	_____________________________
Signature, Witness	**Date**