Bear Lake Community Health Centers

Welcomes You

Thank you for choosing our Health Centers. We will strive to provide you with the best possible healthcare. To help us meet your healthcare needs, please fill this form out completely. If you have any questions, please feel free to ask for our assistance. We are always happy to help!

Patient Information

Patient's Name: Last _____ First _____ Middle _____ Sex: **Male** / **Female**

Marital Status _____ Age _____ Race _____ Language _____ Birth Date ___ /___/_____

Mailing Address: _____ City _____ State _____ Zip _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Social Security #: _____ - _____ - _____

Employer Name _____ Work Phone (_____)_____

Spouse's Last Name _____ First _____ Middle _____

Who do you see for your primary health care?_____ How did you hear about us?_____

Responsible Party Information

Last Name _____ First _____ Middle _____

Relationship to Patient _____ Email Address_____

Mailing Address: _____ City _____ State _____ Zip _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____Social Security #: _____ - ___ - _____ Birth Date ___ /___/____

Employer Name _____ Work Phone (_____)_____

Emergency Contact Information

Please give the name of the nearest relative **not living with you**:
Name _____ Relationship _____ Phone (_____) _____
Complete Address: _____ City, State, Zip _____

Federal Requirement for reporting purposes (Optional): **Household Size: _____**
Household Annual Income Status: _____$0-19,000 _____19,001-25,000
_____25,001-29,000 _____29,001-35,000 _____35,001-40,000 _____40,001-60,000 _____60,001-above

I agree to pay in full at the time of treatment. However, should any balance remain after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to an outside collections agency. If this account is assigned to an outside agency for collections, I agree to pay all attorney fees, court costs, and a collection agency fee up to 40%, which will be added to the outstanding balance of my account with or without suit.

I consent to authorize Bear Lake Community Health Centers to furnish me and my dependants with necessary medical care. This medical care may include radiology exams, laboratory testing, and other diagnostic procedures as may be required. I consent to and authorize Bear Lake Community Health Centers to furnish medical information to any third party who may be responsible for payment of all or part of any charge incurred in this office. I authorize my insurance company, or any responsible third party, to pay benefits directly to Bear Lake Community Health Centers.

I understand that I am financially responsible for the payment of medical charges on my behalf at Bear Lake Community Health Centers, regardless of insurance coverage. I understand that there may be procedures that are not covered by my insurance (example: Medicare, Medicaid, or any commercial insurance that BLCHC holds no contracts with), for which I will be financially responsible. This may include medical, dental, or mental health charges. All co-payments and/or percentages that my insurance requires me to pay must be made at the time services are rendered. If there is no insurance carrier, it is the policy of Bear Lake Community Health Centers that all charges are paid for at the time of service unless prior arrangements have been made.

I further understand that I am responsible to cancel appointments 24 hours in advance. I understand that if a 24-hour notice is not received at the clinic, I may be charged a $35.00 fee for the missed appointment. I also understand that if I am later than 15 minutes for an appointment, it may be considered a no-show and I may also be charged a $35.00 fee and may need to reschedule.

Signature _____ Date _____
Please Print Name _____Relationship to Patient _____

Do you have insurance? ( )Yes ( )No (If yes, please see Page 2)

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Patient's Name: Last _____ First _____ Middle _____

Insurance Information

Primary Medical/Dental Insurance

Policy Holder Info:

Name _____

Relationship to Patient _____

Birthday _____ /_____/_____

Social Security # _____ - _____ - _____

Address_____

ID # _____

Group # _____

Insurance Name _____

Address _____

City, State, Zip _____

Secondary Medical/Dental Insurance

Policy Holder Info:

Name _____

Relationship to Patient _____

Birthday _____ /_____/_____

Social Security # _____ - _____ - _____

Address_____

ID # _____

Group # _____

Insurance Name _____

Address _____

City, State, Zip _____

e-Alert Patient Enrollment

Complete this section to give Bear Lake Community Health Centers permission to correspond about special medical or pharmacy related notification, news, updates, etc.

Phone (_____) _____ - _____ email _____

Signature _____

*Note: Enrolled patients will receive selected messages via text messages as well as any other delivery method you have chosen. For all text messages sent and received, standard text messaging rates will apply. Contact information will be used for Bear Lake Community Health Centers.

Office Use Only:
Notification: Yes No Refused
Already Has? Yes No
Account #_____ Initials _____