



Patient's Name _____
Last First Middle

LCHC# _____ Date of Birth: _____

LINCOLN COMMUNITY HEALTH CENTER, INC.

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatment which may include appropriate laboratory work, i.e. HIV, for me or for the patient for whom I am the parent or legally authorized representative.

I understand that I am responsible for all charges incurred, regardless of my insurance status. I authorize my insurance provider to pay Lincoln Community Health Center for services rendered. I agree to pay for all co-payments and charges that are not covered by my insurance carrier.

I understand that Lincoln Community Health Center will share patient health information according to federal and state law for treatment, payment, and operations.

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

Date: _____



LINCOLN COMMUNITY HEALTH CENTER, INC.

1301 Fayetteville Street • P.O. Box 52119
Durham, North Carolina 27717-2119
(919) 956-4000 • FAX (919) 687-4257

REGISTRATION AND INCOME VERIFICATION STATEMENT

I certify that the income and other registration information given by me to Lincoln Community Health Center staff for the purpose of receiving services is accurate.

I further understand that my health center records are subject to federal audit, and that if Lincoln Community Health Center determines I have falsified this information, I will be notified and then dropped as a registrant and may no longer receive services at the Center, except in a life threatening emergency.

By signing this letter, I _____, certify that I have read and fully understand the contents of this letter.

Patient's Signature _____
(If minor, guardian's signature)

Witness: _____
(Signature of Interviewer)

Date: _____

LINCOLN COMMUNITY HEALTH CENTER

SLIDING SCALE POLICY:

Lincoln Community Health Center is committed to fulfilling its mission as a safety net provider thus structuring its charges based on a sliding fee scale methodology that is governed by the annually published federal poverty guidelines. Lincoln Community Health Center's billing and collection efforts are designed to ascertain fiscal responsibility while avoiding being a barrier to access to care and are consistent with its mission to provide comprehensive primary and preventive health care in a courteous, professional and personalized manner. The appropriate discounts will be based solely on income and family size in conformance with the established sliding fee scale.

All patients wishing to be considered for sliding scale discount must provide proof of income at the time of initial registration or annual update.

LINCOLN COMMUNITY HEALTH CENTER, INC.
APPLICATION FOR REDUCED FEES

Name _____ Date _____

Mailing Address _____ DOB _____

City _____ ZIP _____ Phone Number _____

Total Number in Family _____ Payment Code _____

INCOME VERIFICATION: List all sources of income as indicated. Verify with pay statement, check stub, income tax reports, etc.

Family Member's Name	DOB	Social Security No.	Medical Rec No.
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

GROSS EARNINGS OF EACH FAMILY MEMBER:

Family Member's Name	Bi-Weekly	Monthly	Per Year
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
Total Gross Earnings:	x26=	x12=	\$ _____

SOURCE OF UNEARNED INCOME:

SOURCE	YES	NO	PROOF	AMOUNT MONTHLY
Social Security	_____	_____	_____	_____
Supplemental Security Income (SSI)	_____	_____	_____	_____
Aid to Disabled/Blind	_____	_____	_____	_____
Aid to Families/Dependent Children (Medicaid)	_____	_____	_____	_____
Retirement/Pensions/Annuity Payments	_____	_____	_____	_____
Veterans Benefits	_____	_____	_____	_____
Child Support/Alimony Payments	_____	_____	_____	_____
Income from Self Employment (Form 1040C)	_____	_____	_____	_____
Other Unearned Income	_____	_____	_____	_____

TOTAL UNEARNED FAMILY INCOME/MONTH \$ _____ x12 Months \$ _____

ANNUAL FAMILY INCOME FROM ALL SOURCES \$ _____ FAMILY SIZE: _____

I hereby certify that the above information concerning my income is true and complete and that I have no income other than that listed above. I promise to notify LCHC at once if there is a change in my income, family size, mailing address, or telephone number.

Witness: _____ Applicant: _____
 LCHC Staff

Lincoln Community Health Center, Inc.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that we keep about you .
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Account Number: _____

Name of Patient: _____ **DOB:** _____
(Please print)

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient's Signature

Date

Signature of Parent or Patient's Representative (if applicable)

Date

Description of Legal Authority to Act on Behalf of Patient



Patient's Name _____
Last First Middle

LCHC# _____

LINCOLN COMMUNITY HEALTH CENTER, INC:

ONE TIME AUTHORIZATION
INSURANCE BENEFIT ASSIGNMENT

I hereby authorize and request that payment of Medicare, Medicaid and any other Third Party Insurance benefits held by me be paid directly to Lincoln Community Health Center, Inc. for any services furnished to me by any of the providers employed or contracted with by that facility. I authorize Lincoln Community Health Center, Inc. to release any medical record information needed to file appropriate insurance claims to determine these benefits. I allow Lincoln Community Health Center, Inc. to copy all of my insurance information and to keep copies of the same in my permanent file

1. **MEDICARE:**

Name of Beneficiary

Medicare ID Number

2. **MEDICAID:**

Name of Beneficiary

Medicaid ID Number

3. **PRIVATE INSURANCE CARRIERS:**

Name of Policy Holder

ID/Certificate Number

Name of Employer

Group Number

4. **OBTAIN COPY OF INSURANCE CARD AND ATTACH.**

I understand that I am responsible for any charges or co-payments not covered by this assignment or charges that are specifically excluded from coverage by Medicare, Medicaid or the Private Insurance listed above.

Signature of Patient

Signature of Witness

Date: _____

Date: _____

REG. NUMBER

NAME



Lincoln Community Health Center, Inc.

**Medicare Secondary Payer (MSP)
Questionnaire**

**- Admission Questions to ask Medicare Beneficiaries
upon each inpatient and outpatient admission.**

Medicare Secondary Payer (MSP)

Provider Billing Requirements

Part I

1. Are you receiving Black Lung (BL) Benefits?

Yes; Date benefits began: CCYY/MM/DD

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

No.

2. Are the services to be paid by a government program such as a research grant?

Yes; Government Program will pay primary benefits for these services

No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

Yes.

DVA IS PRIMARY FOR THESE SERVICES.

No.

4. Was the illness/injury due to a work related accident/condition?

Yes; Date of injury/illness: CCYY/MM/DD

Name and address of WC plan:

Policy or identification number: _____

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

No. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?

Yes; Date of accident: CCYY/MM/DD

No. **GO TO PART III**

2. What type of accident caused the illness/injury?

Automobile.

Non-automobile.

Name and address of no-fault or liability insurer:

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

Other

3. Was another party responsible for this accident?

Yes;

Name and address of any liability insurer:

Insurance claim number: _____

**LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS
RELATED TO THE ACCIDENT. GO TO PART III.**

No. **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:

Age. **Go to Part IV.**

Disability. **Go to Part V.**

ESRD. **Go to Part VI.**

Part IV - Age

1. Are you currently employed?

Yes.

Name and address of your employer:

No. Date of retirement: CCYY/MM/DD

No. *Never Employed*

2. Is your spouse currently employed?

Yes.

Name and address of spouse's employer:

No. Date of retirement: CCYY/MM/DD

No. *Never Employed*

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

Yes.

No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

No. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part V - Disability

1. Are you currently employed?

Yes.

Name and address of your employer:

No. Date of retirement: CCYY/MM/DD

2. Is a family member currently employed?

Yes.

Name and address of your employer:

No.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

Yes.

No. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 100 or more employees?

 Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

Membership Number: _____

 No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

Yes. Date of transplant: CCYY/MM/DD

No.

3. Have you received maintenance dialysis treatments?

Yes. Date dialysis began: CCYY/MM/DD

If you participated in a self-dialysis training program, provide date training started:
CCYY/MM/DD

No

4. Are you within the 30-month coordination period?

Yes

No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

Yes.

No. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. *Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?*

Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?)

Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in CWF for the beneficiary, the provider still asks the questions found in §20.1 and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Signed: _____ Date: _____

Witness: _____ Date: _____

Please attach a copy of the Medicare Card to this document