



Patient's Name: _____
Last First Middle

Acct# _____ Date Of Birth: _____

**LINCOLN COMMUNITY HEALTH CENTER
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 OR Legal 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

Acct# _____

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 statement, I _____, certify that I have read and fully understand the contents of this statement.

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

Patient's Signature _____

(If minor, guardian's signature)

Does the patient have any form of Health Insurance, Medicaid, Medicare or any other type? YES _____ NO _____

Patients relationship to insured _____.

Is the patient a Veteran of the Armed Forces? YES _____ NO _____

Marital Status? Single _____ Married _____ Other _____

Employment Status? Employed _____ Full-time _____ Part-time _____ Unemployed _____

Student Status? Not Student _____ Full-time _____ Part-time _____

Patients Race

_____ Asian
_____ Native Hawaiian
_____ Other Pacific Islander
_____ Black/African American
_____ American Indian/Alaska Native
_____ White
_____ More than one race
_____ Unreported/Refused to report

Ethnicity

Hispanic/Latino YES _____ NO _____

What is your preferred language? _____

Are interpreter services needed? YES _____ NO _____

Date: _____

**LINCOLN COMMUNITY HEALTH CENTER, INC.
APPLICATION FOR REDUCED FEES**

Name: _____ Date: _____

Mailing Address _____ DOB _____

City _____ Zip _____ Phone Number _____

Total Number in Family _____ Payment Code _____

Email _____

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

Family Member's Names	DOB	SSN	Acct#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GROSS EARNINGS OF EACH FAMILY MEMBER

Family Member's Name	Biweekly	Monthly	Per Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total Gross Earnings	x26=	x12=	\$ _____

SOURCE OF UNEARNED INCOME

<u>SOURCE</u>	<u>YES</u>	<u>NO</u>	<u>PROOF</u>	<u>AMT</u>	<u>MONTHLY</u>
Social Security	_____	_____	_____	_____	_____
Supplemental Security Income (SSI)	_____	_____	_____	_____	_____
Aid to Disabled/Blind	_____	_____	_____	_____	_____
Aid to Families/Dependent Children (Medicaid)	_____	_____	_____	_____	_____
Retirement/Pensions/Annuity Payments	_____	_____	_____	_____	_____
Veteran 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 \$ _____

I 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.

Applicant: _____

Patient's Name: _____
Last First Middle

Acct# _____ Date Of Birth: _____

LINCOLN COMMUNITY HEALTH CENTER, INC:
ONE TIME AUTHORIZATION
INSURANCE BENEFIT ASSIGNMENT

I hereby authorize and request that payment 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 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 Health Insurance Claim No.

2. MEDICAID:

Name of Beneficiary Medicaid ID Number

3. OTHER INSURANCE CARRIERS:

Name of Policy Holder Certificate Number

Name of Employer (Certificate Holder) Group Number

Claims Mailing Address

I understand that I am responsible for any charges 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 Date: _____