Mitchell County Health Department
310 W. 8th St Beloit, KS 67420
785-738-5175

Patient Information

Patient Name: _____ Date of Birth: _____

Full Address: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Race: _____

Social Security #: _____ Primary Care Physician & Address: _____

Subscriber of Insurance or Person Responsible for the Bill

Do you have an active insurance: _____ Yes _____ No

Full Name: _____ Date of Birth: _____

Full Address: _____ Sex: _____

Phone Number : _____ Relationship to Patient: _____

Insurance Name: _____ Insurance ID #: _____ Group #: _____

Please notify the health department if you have a secondary insurance.

Emergency Contact

Full Name: _____ Relationship to Patient: _____

Full Address : _____ Home/Cell Phone: _____

Parent/Guardian Information

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Home/Cell Phone: _____ SS #: _____

Full Address: _____

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Financial Obligation

It is my request that the Mitchell County Health Department perform services for me/my child.

For applicable services billable to insurance, the Mitchell County Health Department (MCHD) is submitting a claim to my insurance company for the services and charges. I have been informed and do understand that I am held responsible for any deductible and co-payment amounts for all services provided. Furthermore, it is my wish to have these services performed even though they may not be paid by my insurance company. Should the claim be denied due to policy restrictions, non-medical necessity, lack of referral, or other limitations as imposed by my policy, I understand that I will be held personally responsible for the entire amount. **If I do not have insurance coverage at the time services are performed, or services are not billable to insurance, I understand that I am fully responsible for the charges related to the services.**

I understand some services at the MCHD may be part of a program where a sliding fee scale is available and providing the household income is a program requirement. I understand that if I do not provide household income I will be billed at 100%.

Household Income: _____ Unknown / Refused: _____ Household Size: _____

Signature: _____ Date: _____ Relationship to Patient: _____

Acknowledgement of Receipt of Revised Notice of Privacy Practices

I acknowledge that I have received a copy of Mitchell County Health Department Notice of Privacy Practices effective June 19th, 2023 (updated on June 19th, 2023).

Signature: _____ Date: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

Signature of Staff Reviewing: _____ Date: _____