Portsmouth City Health Department Clinic's
Patient Billing Information

Updated Information _____

PATIENT INFORMATION

Sliding Fee %
Expires_____

PATIENT

Legal Name_____ Date of Birth_____
Last First M. Nickname

Social Security#_____

Address_____
City State Zip County

Phone #_____ Work/Msg Phone_____ Cell Phone_____

Employer_____ Employer Phone #_____

Primary Ins._____ **Second Ins.**_____

Policy Holder_____ Policy Holder_____
Name Name

ID#_____ ID#_____

Relationship to Patient_____ DOB___/___/___ Relationship to Patient_____ DOB___/___/___

Medicare#_____ Medicaid_____

HEAD OF HOUSEHOLD/RESPONSIBLE PARTY

Name_____ Relationship_____

Employer_____ Employer Phone #_____

Primary Ins._____ Secondary Holder_____

Policy Holder_____ Policy Holder_____
Name Name

ID#_____ ID#_____

Relationship to Patient _____DOB___/___/___ Relationship to Patient_____ DOB___/___/___

Income Information for:

Patient _____
Head of Household _____
Other Income _____
Total Income _____

Total Dependents in Household _____

Proof of income must be provided

Proof of income source: Pay stubs, child support, unemployment, disability, social security, etc.
(Related by blood or marriage)

□ I am refusing the sliding fee discount

□ Under Penalties of perjury, I certify that I have no income of any kind or that this income information is true to the best of my knowledge.
Signature_____

I certify that as of this date, the above information is correct to the best if my knowledge. I authorize payment of all insurance policy benefits, to be paid directly to Portsmouth Coty Health Department Clinic's. Furthermore, I authorize Portsmouth City Health Department Clinic's to release all medical information to any physician, agency (ies). I also, understand that failure to notify Portsmouth City Health Department Clinic's of any addition or corrections will terminate my eligibility for the sliding fee, should I qualify. Any false statement will jeopardize the discount and result in full payment of my account.
Payment is expected at the time of service, including all co pays.

Patient/Guarantor Signature_____ Date_____

Employee Signature_____ Date_____ Copied Cards Y/N

Please Complete Back of Form

LIST BELOW ALL FAMILY MEMBERS LIVING IN HOUSEHOLD

Related by Marriage or Blood (only)

Legal Name	Mothers Maiden Name (Only children under 18)	Social Security #	Date of Birth	Relationship

**********OHIO DEPARTMENT OF HEALTH, CHILD, AND FAMILY HEALTH SERVICES, CONSENT FORM**********

Well Child, Prenatal and Family Planning Services

Portsmouth City Health Department Clinic's receives funds from the Ohio Department of Health (ODH) to provide health services. We are required to report this information to ODH. A client's name, SS#, and other personal identifying information is obtained for this purpose. This information may be used by ODH to evaluate funded clinics. This information is also matched with other program such as WIC. The information may also be used to determine if out clients are eligible for programs such as Healthy Start.

Authority to collect the SS# is found in Ohio Revised Code Selection 3701.023(A). The information would never be used in reports that would identify clients individually. You have the right to not give the SS# or other personal identifying information to ODH. Refusal will not affect client's eligibility to receive healthcare services.

Please complete following section and sign below.

I DO/ DO NOT (Circle One) give my permission to provide ODH with the name social security # or other Identifying information regarding the following clients:

List client names below

_____ Parent/Guardian Signature