PATIENT INFORMATION SHEET – CLCHD Nursing **ADULT**

Cheyenne Laramie County Public Health

Patient: (Mr./Mrs./Ms.)

First Name: _____ MI: _____ Last Name: _____

Sex: M / F Date of Birth: _____ Age: _____ Reason For Visit: _____

Emergency Contact Person: _____ Telephone: _____

Doctor: _____

Responsible Party Information: Self / Spouse / Mother / Father / Employer _____

Name: _____ DOB: _____

Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: Primary

Name: _____

Send Claims to: _____

_____

_____

Patient ID #: _____

Subscriber Information:

Name: _____

DOB: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Insurance Company: Secondary

Name: _____

Send Claims to: _____

_____

_____

Patient ID #: _____

Insured Party / Person:

Name: _____

DOB: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Payment:

We accept the following Insurances:

Blue Cross/Blue Shield of WY / Cigna / First Choice of the Midwest / Kid Care Chip
Medicare Part B, C & D / United Healthcare / UMR / Wyoming Medicaid/Mountain Health CO-OP

- Payment is due at the time of service for those services not covered by your insurance. It is **your** responsibility to pay any deductible/co-insurance or any outstanding balance not paid by your insurance company.
- Service Programs for International Travel Vaccines including Counseling/Work or College entry Services/or Immigration Services, including lab services for these Programs, will be paid at the time of Service. We will bill for only those items insurance will pay .
- My signature below is my authorization for the release of information necessary to process my claim(s) to insurance or other payers.
- Statements will be mailed monthly for any patient or company where there is a balance due. This balance will be due when you receive the statement.
- If this account is turned over to collections, I agree to pay all collection costs, attorney fees, and or court costs.
- **I hereby authorize payment** directly to Cheyenne Laramie County Health Dept., Nursing Division, and otherwise payable to me. (This is for insurance companies that we participate with.)

SIGNATURE: _____ **DATE:** _____