LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

Patient Name: _____

MRN:_____PCP/PCD:_____

Responsible Party and Billing Information

La Clinica gets support from the government to help patients who qualify cover the cost of services. Income guidelines are set annually by the federal government. Even if you choose not to apply, we are required to ask for some financial information about everyone served at our health centers. We will keep all personal information private as outlined in our Notice of Privacy Practices.

Part 1: Responsible party—If you or an immediate family member already have an account with La Clinica, please provide the information of that account holder.		
☐ The responsible party is the same as the patient registering for services.		
Legal guardian/parent name:	Date of birth:	Social Security #:
Mailing address: *(Include city, state, zip code.)*		
Home phone #	Cell phone #	Email:

Part 2: Tell us about your insurance. We bill all insurance provided to us. Please check with your insurance regarding contracts with our facility and any out-of-pocket expenses.	
Insurance name:	Claim address:
Name of primary insured:	Date of birth: Relationship to patient:
Subscriber/member ID:	Group #:

Part 3: Tell us about your financial situation. You may be eligible for grant support to cover the cost of services.	
Annual household income:	Family size:
☐ I want to apply for financial assistance.	☐ I do <u>not</u> want to apply for financial assistance.

Billing disclosure:
I understand that if I choose not to disclose my income or provide my insurance information I will be billed for all services rendered.

Responsible party signature:	Date:
Printed name:	

For Staff Use Only: Income verified in chart #_____ Staff Name: _____