Kaniksu Health Services

KHS Bonners Ferry Clinic: 6615 Comanche Street - Bonners Ferry, ID 83805 208-267-1718
KHS Sandpoint Clinic: 30410 Highway 200 – Ponderay, ID 83852 208-263-7101
KHS Sandpoint Pediatric Clinic: 420 N Second Ave – Sandpoint ID 83864 208-265-2242
KHS Priest River Clinic: 6509 Hwy 2 Suite 101, Priest River, ID 83856 208-448-2321

Patient:
Last name ______ **First name** ______ **Middle** ______ **M / F**

Date of Birth______ **Age**______ **SS#**______ **Home Ph. #**______ **Alternate Ph. #**______

E-mail Address: ______ **Preferred Method of Contact**______

Mailing Address ______ **City**______ **State**______ **Zip** ______

Employment ❒Year-round ❒Seasonal ❒Self Employed ❒Retired ❒Unemployed ❒Disabled ❒Student

Migrant Worker ❒ Yes ❒ No **Patient Primary Doctor:** ______
Veteran ❒Yes ❒ No
Homeless ❒Yes **Do you have insurance? ❒ Yes ❒ No** **Please give cards to receptionist for copying**
Insurance Carrier Name: **Policy Holder Name:**

❒Parent / ❒Guardian / ❒Spouse / ❒ Emergency Contact **❒Single / ❒Married / ❒Widowed**

First name______ **Middle**______ **Last**______ **M / F**

Relationship to patient ______ **Home Ph. #** ______ **Date of Birth:**______

Please circle "Size of Family Unit" and the "Total Household Income" on the chart below:

1	$12,060	$12,061 to $16,281	$16,282 to $18,090	$18,091 to $23,999	$24,000
2	$16,240	$16,241 to $21,924	$21,925 to $24,360	$24,361 to $32,318	$32,319
3	$20,420	$20,421 to $27,567	$27,568 to $30,630	$30,631 to $40,636	$40,637
4	$24,600	$24,601 to $33,210	$33,211 to $36,900	$36,901 to $48,954	$48,955
5	$28,780	$28,781 to $38,853	$38,854 to $43,170	$43,171 to $57,272	$57,273
6	$32,960	$32,961 to $44,496	$44,497 to $49,440	$49,441 to $65,590	$65,591
7	$37,140	$37,141 to $50,139	$50,140 to $55,710	$55,711 to $73,909	$73,910
8	$41,320	$41,321 to $55,782	$55,783 to $61,980	$61,981 to $82,227	$82,228
9	$45,500	$45,501 to $61,425	$61,426 to $68,250	$68,251 to $90,545	$90,546

If household size and income exceeds what is on this chart please fill in ___ Annual income $______

I hereby agree that the above information is true and correct to the best of my knowledge.

Signature of Patient/Guardian______ **Date**______

******Sliding Fee Wavier of Participation******

I decline participation in the Sliding Fee Discount Program and I understand that I am responsible for the entire bill or any portion that remains after insurance payments.

Signature of Patient/Guardian______ **Date**______

Race: ❒White (Not Hispanic or Latino) ❒African American (Not Hispanic or Latino) ❒Native American ❒Native Alaskan ❒Pacific Islander ❒Asian ❒Native Hawaiian ❒ Other ______

Ethnicity: ❒Hispanic/ Latino ❒ Non-Hispanic/ Latino ❒ Unknown **Primary language spoken in your household** ❒ English ❒ Spanish ❒ Other_____

I hereby authorize Kaniksu Health Services to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied. In the event that insurance benefits are paid directly to me, I will endorse to KHS all checks for such payments. I also authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby agree that I am financially responsible for all charges incurred for the services provided.

Signature ______ **Parent/Guardian (if minor)** ______ **Date:** ______