CENTRAL DISTRICT HEALTH DEPARTMENT

707 N. Armstrong Place
Boise, Idaho 83704
Phone: (208) 327-7400
Fax: (208) 327-8579

For Office Use Only

Client #_____

Fee Category #_____

Has Ins. Medicaid No Ins.

Chart Ready Time: ____:____ am/pm

Initials: _____

Client Registration Form

Date of Birth: _____ **Age**: _____

Full Name

_____ _____ _____ _____

First **MI** **Last** **Maiden Name**

Please Provide the Following Contact Information

_____ _____

Address **Apt #**

_____ _____ _____

City **State** **Zip Code**

Home _____ **Cell** _____

Please select the methods that we may contact you for test results, visit follow-up, billing, etc.

Phone: Yes ☐ No ☐ **Texting**: Yes ☐ No ☐ **Mail**: Yes ☐ No ☐

Mother's Maiden Name: _____ **Password**: _____

Please Initial

_____ I have read and acknowledge Central District Health Department's **Notice of Privacy Practices**.

_____ I have read, fully understand and agree to the terms included in CDHD's **Financial Policy.** Furthermore, I acknowledge and accept that CDHD does not currently participate in Medicare, PPO, HMO, or Participating Provider Plans. I understand that by choosing not to disclose my finances or use my health insurance coverage, I will be responsible for all fees at time of service. I acknowledge it is my responsibility to know which medical services are covered by my insurance plan.

_____ I have read, fully understand, and agree with the terms included in the **Consent for Services and Authorization to Release Medical Information by Telephone**.

_____ I understand and acknowledge that I may incur laboratory fees if I do not meet testing criteria, and payment will be expected at time of service for lab testing.

_____ _____

Signature Today's Date

Submit