

(Please Print)

| Today's Date: | | | Primary Care Provider: | | | | | | | | |
|--|------------|---------|-------------------------|--|-------------|--------------------------|--|-------------|----------|-------------------|--------------|
| | | | | Patien | ıt Infor | rmation | | | | | |
| Patient Name (Last, First, Middle): | | | | | Mr. Mrs. | Ms. Miss | Forme | Name(| s): | | |
| Is this your legal name? Yes No | | | If not, | f not, what is your legal name? | | | | | | | |
| Sex: Male Female Other DOB: | | | | Age: Social Security #: | | | urity #: | | | | |
| Primary Phone #: Second | | | dary Phone #: Email Add | | | \ddress: | | | | | |
| Street Address: | | | • | | | | ······································ | | P.O. Bo | ox: | |
| City: | | | | State: | | | | | ZIP Co | de: | |
| Patient Occupation: Patie | | | Patient | Employ | /er: | · | | | Employ | er Phor | ne #: |
| School Currently Attend | ding (If C | hild): | 1 | | | Does c | hild rec | eive free | reduced | lunches | s: Yes No NA |
| Spouse/Guardian/Par | ent Info | rmation | | Addres | ss: | • | | | | Phone | #: |
| Name: | | | | | | | | | | | |
| Guardian/Parent Infor | mation: | | | Address: Phone #: | | | #: | | | | |
| Name: | | | | | | | | | | J. Maria Magazina | |
| Insu | rance In | formati | on (Plea | ase give | e your | insurar | ice cai | d to the | receptio | nist) | |
| Person Responsible for | r Bill: | Birth D | ate: | Addres | ss (If di | ifferent): | | | | Primary | y Phone #: |
| Is this person a patient | here? Y | es No | Patient | relationship to subscriber: Self Spouse Child Step | | | d Step- | Child Other | | | |
| Occupation: | Employ | er: | | Employer Address: Employer | | | er Phone #: | | | | |
| Primary Insurance: Me | dicare | Medicai | d Blue | Cross | Blue S | hield l | Jnited I | Healthcar | e Othe | r: | |
| Subscriber Name: | | Subscr | iber SSN | N: | | Bi | Birth Date: | | | Co-Payment: | |
| Policy #: | | | Group | | roup #: | up #: | | \$ | | | |
| Secondary Insurance (if applicable): Subscri | | | riber Name: | | Policy #: | | | | | | |
| | | | | | | | Group #: | | | | |
| Patient relationship to subscriber: Self Spouse Child Step-Child Other | | | | | | | | | | | |
| | | | l | n Case | of Em | ergency | / | | | | |
| Name of local friend or relative (not living at the | | | same a | ddress |): | Relationship to patient: | | | | | |
| Primary Phone #: | | | | | Second | lary Ph | ary Phone #: | | | | |





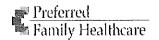
The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of Preferred Family Healthcare/ Clarity. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

| Please check one box in ea | ach of the following categories | 31 | | | |
|---|---|--|--|--|--|
| Ethnlcity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Cher (Specify): ☐ Asian ☐ Native Hawaiian ☐ Primary Language: ☐ English ☐ Other (Specify): ☐ Marital Status: ☐ Single ☐ Married | | Gender Identity: ☐ Male ☐ Female ☐ Transgender (Female to Ma ☐ Transgender (Male to Female) ☐ Other ☐ Decline to Disclose | Sexual Orientation: Straight Bisexual Lesbian/Gay Don't Know Decline to Disclose | | |
| ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White (not Hispanic or Latino) ☐ Hispanic or Latino (all races) ☐ Decline to Disclose | ☐ Divorced ☐ Widowed ☐ Legally Separated Are you a Veteran? ☐ Yes ☐ No | Housing Status: Own/Rent Homeless Transitional Doubling Up Shelter Permanent Supportive | Employment Status: Patient: | | |
| □ Newspaper □ Social Media □ He (Specify): | al(Physician) □ Billboard □ Magazine ealth Fair □ Other | If yes, who is your health | Directive? ☐ Yes ☐ No care agent? | | |
| Family Members: For the protection Healthcare/Clarity? □ Yes | on of your confidentiality, do you hav □ No If yes, who? | e any family members who worl | c at Preferred Family | | |
| List ALL members of the h | ousehold. Include all persons | living in the household (| related or non-related): | | |
| Na | me: | Relationship: | | | |
| | | | | | |
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| | | • | | | |
| | Sources of | | | | |
| Gross Wages/Salaries/Ti | <u> </u> | | ☐ Veteran's Benefits | | |
| Unemployment Compensation | Social Secui | • | Regular Contributions from person not living in the | | |
| ☐ Worker's Compensation | Income | al Security | household | | |
| Earnings from need-base | ed Survivor's B | enefits | Any other income not included in the above list | | |
| employment programs | Pensions | | included in the above list | | |
| Total Annual Household Inc | come: \$ | | | | |
| have read and completed the attached form and certify the information I entered is true and complete to the best of my knowledge. In addition, I have provided verification or provided self-attestation of all household income sources in order for this application to be processed. I understand completion of this form does not guarantee a discount, and if I do not qualify for a discount, I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform Preferred Family Healthcare/Clarity at my next visit. I also agree to provide updated income verification as often as possible. All information submitted will remain confidential. I understand of I qualify for the sliding scale program, there may be a minimum payment required per appointment. (Signature of this form serves as acknowledgement) | | | | | |
| (For Internal Use Only): | | | | | |
| Based on the information above, yo | ou qualify for on the sliding fee s | scale and will be charged \$ | per 🗌 visit 🗎 month. | | |

Updated 11/2021



Staff Signature (if applicable):



Acknowledgement & Consent to Treat

The below statements apply to all healthcare providers providing services through Preferred Family Healthcare/Clarity. They include services provided by employees, contractors, agencies or other entities affiliated with Preferred Family Healthcare, Inc. Please read carefully and be sure that you understand each statement below; we will be glad to answer any questions that you may have. Signature of this form serves as acknowledgement of the following:

Insurance and Patient Responsibility: Insurance claims are submitted on your behalf by Preferred Family Healthcare/Clarity. Deductibles and copays are due at the time of check-in. Clients are not responsible for any copays or deductibles that accrue from participation in the TAX program. You are responsible for knowing your insurance coverage and if our providers are in-network or not in-network with your insurance plan. For any questions regarding your coverage, we recommend you contact your carrier or plan provider directly. You will need to update or verify personal information at each visit and show your current insurance card. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file or are unable to verify your benefits, you will be considered a self-pay patient. As a self-pay patient, a minimum fee (as determined by location) may be expected to be paid at the time of service. If you can provide your insurance card and the insurance pays your claim in full, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled.

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Preferred Family Healthcare/Clarity. I understand I am financially responsible for any balance. I also authorize Preferred Family Healthcare/Clarity or my insurance company to release any information required to process my claims.

Release of Information for Billing: I authorize Preferred Family Healthcare/Clarity to release medical and billing information for the purpose of payment collection to all parties responsible for payment on my behalf including the entities listed above under insurance information, and Substance Use Disorder funding sources including The Department of Health & Human Services, and the following (as applicable):

Missouri:

- •United States Probation & Pretrial Services Western District of Missouri
- . Community & Children's Resource Board of St. Charles County
- •Franklin County Children & Families Community Resource Board
- State of Missouri Department of Social Services
- Children's Services Fund of Jackson County
- Jordan Valley Community Health Center
- ·St. Louis County Children's Service Fund

•St. Louis Mental Health Board

- •Missouri Foundation for Health
- •Missouri Department of Mental Health
- Office of State Courts Administrator
- •12th/45th Circuit Treatment Court
- •9th/41st Circuit Treatment/Drug Court
- •Community Foundation of the Ozarks

<u>Illinols:</u>

•Adams County Probation
•Pike County Probation

Kansas:

•United Community Services of Johnson County

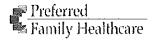
The information released will be limited to that needed to collect payment and may include release of alcohol or drug abuse (if applicable) information. Authorization includes the release of preadmission, recertification, and appeal information which may include diagnosis, symptoms, treatment plans, test results, or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable). This consent will stay in effect until the account is settled.

Notice of Privacy Practices: I acknowledge I have been offered a copy of the Notice of Privacy Practices.

Consumer/Program Orientation: I acknowledge I have been offered a copy of the Consumer Orientation Guide/Program Handbook. I understand the consumer rights and responsibilities, services offered, treatment planning, emergency service availability, request for change and grievance procedures. I further understand I may request additional copies of the Consumer Orientation Guide/Program Handbook from any PFH office or provider at any time.

<u>Confidentiality Practices:</u> I understand my records of treatment will be kept confidential and released only with a signed consent form except when required by law. Providers of services have a duty to protect, warn and/or report the following:
•Threat of harm to self •Threat of harm to others • Abuse, neglect or exploitation of children and/or vulnerable adults, including acts of domestic violence.





<u>Photo Consent:</u> I give my consent to have a photo taken for office identification purposes. This photo will be kept confidential and stored in my electronic medical record. I understand having a photo on file may be mandatory for programs in which medications are staff and/or self-administered and failure to do so may prevent program participation.

Substance Use Disorder Records: I understand substance use disorder records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse and can only be disclosed with 1) My written consent 2) A court order 3) To qualified personnel for a medical emergency, research, audit, or program evaluation 4) In reference to a threat or crime committed at the program or against program personnel or as otherwise provided for in the regulations. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. (See 42 USC 290dd-3, 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

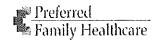
Medications: I permit Preferred Family Healthcare/Clarity to store and manage my medications while in residential/RCF/PSR programs including prescription, over-the-counter, and those delivered to or brought on-site. I understand Preferred Family Healthcare/Clarity will administer or observe my self-administration of medications. I agree to allow Preferred Family Healthcare/Clarity or its designated representatives to provide over-the-counter medications such as Ibuprofen, Acetaminophen, Chewable Antacids, and topical medications and pick up/accept delivery of medications ordered for me from the pharmacy as well as disposal of medications if they are discontinued by the physician or I leave Against Medical Advice.

HIE: Preferred Family Healthcare/Clarity may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your healthcare providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STI treatment and test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at pfh.org/privacy or you may call us at 1-855-450-5770. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

Communicable Disease Reporting: Unless being seen for symptoms of a contagious virus or illness such as COVID-19, SARS, or Influenza A/B, I affirm I do not have current symptoms, current or recent diagnosis, nor have I resided with or been in close proximity to anyone who I have knowledge of having been diagnosed with a contagious illness. Should my health condition change or I become aware of an exposure, I am to report this to my Preferred Family Healthcare/Clarity provider immediately. I consent to allow Preferred Family Healthcare/Clarity to report communicable diseases to the Department of Health and Senior Services as outlined by the agency, including cooperation with investigations and providing client information as requested. I acknowledge Preferred Family Healthcare/Clarity recommends I wear a mask at all times when present within their facility(ies). Some facilities may allow me to opt out of wearing a mask. This is subject to change at any time as determined by site leadership based on current local conditions and CDC recommendations. I agree to release Preferred Family Healthcare/Clarity of any liability should I contract COVID-19, Influenza A/B, SARS, or any other contagious illness.

<u>Medical and Psychiatric Advance Directives:</u> I permit Preferred Family Healthcare/Clarity to obtain emergency medical and/or psychiatric treatment deemed necessary for my physical and mental health unless otherwise specified

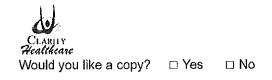


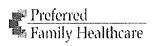


through written consent. I understand I will be responsible for payments not covered under insurance benefits for these services. I also give permission to Preferred Family Healthcare/Clarity and other healthcare entities of which I receive services to share necessary medical information for healthcare and payment purposes.

Please indicate your consent to the following by checking the box on the left:

| participate in these activities at my own risk. I und shall not be liable for any claims arising out of part | Clarity programs include recreation and physical exercise. I consent to lerstand Preferred Family Healthcare/Clarity and its representatives icipation. If there is a reason I cannot participate, I understand it is my |
|--|---|
| (A.R.TC) program throughout treatment. I hereby create, in whole or in part, during my participation, reproductions of my projects may be used as mark | tunities to participate in the Achieving Recovery Through Creativity y assign, transfer and convey all of my right title and interest in any art I to Preferred Family Healthcare/Clarity. I understand photographs and ceting and fundraising materials including but not limited to brochures, additional consideration will be owed to me for any of these purposes. |
| community activities which may result in photographinterviewed, photographed and/or videotaped to sl Healthcare/Clarity, for the purpose of creating eductoring the community. Participation in the about the such as my name and hometown as well as no guarantee the information will not be picked up Healthcare/Clarity, it's affiliates, and employees are | hay be given opportunities to participate in public contests, shows or other and/or press articles. I may also be given opportunities to be hare my personal story or experiences with Preferred Family cational or marketing materials, which may then be distributed broadly ove-mentioned opportunities may disclose personal information to the a my involvement in treatment. Once materials are distributed, there is by the media or be posted on the internet. Preferred Family e not legally responsible or liable for the re-disclosure of the information, indatory and my voluntary agreement and participation constitutes |
| participation in these services is not mandatory an refuse to participate in Telehealth services at any t Healthcare/Clarity. Telehealth services are subject there will be no dissemination, storage, or retention informed of all parties who are present during the | s available to me through participation in Telehealth and that d I will be informed of alternative resources for needed care. I can ime without affecting my right to future care through Preferred Family t to the same confidentiality laws as services provided in person and n of video interaction produced during Telehealth services. I will be Telehealth service and I have the right to exclude anyone at my request. ion should a mental health or medical emergency arise. |
| me about my protected health information, the carrinclude, but are not limited to, refill and appointment Family Healthcare/Clarity may contract with other consent extends to telephone communications by telephone and email may increase the risk of inadvented to the contract with the carrier and the ca | erred Family Healthcare/Clarity will at times need to communicate with e I receive, my bill, and other services. These communications may not reminders, scheduling requests, and referrals. I understand Preferred organizations to manage or collect for the services provided to me. This these organizations as well. I understand that use of wireless evertent or unauthorized disclosure of my information to third parties. I commation I receive and consent to receive communication through the Text Message Email All |
| by Preferred Family Healthcare/Clarity and my | been informed and understand the nature of the services provided right to request discharge if at any time I do not wish to continue ervices and treatment. |
| Patient Signature: | Date: |
| Legal Guardian Signature: | Date: |
| Relationship to patient: Parent Legal Guardian | Other (specify): |





PREFERRED FAMILY HEALTHCARE, INC. AUTHORIZATION FOR DISCLOSURE

| Client/Patient Full Name: | | | | Date of Birth: | | | |
|--|---|--|---|--|---|--|--|
| Authorizes PREFERRED | FAMILY HEALTHO | ARE, INC | C. to commi | unicate with | , disclose to and obtain from: | | |
| Name/Entity: Address: City/State/Zip: Phone: Purpose of Disclosure: | Continuity of Care Other: | _ | | Research | Individual's Request | | |
| The following information All records, which work Intake assessment Medication history Progress notes/ case Immunization records Physical health inform Employment Verifical Vocational Information STD testing, whether communicable, non-corgonorrhea, HIV, or AIDS Other (please list): | will include all of the Communicable, or venical and communicable, or venicable, or | he below viedgemence use of treatment other dreass toward dogical/Prion recorree, and/o | ent of my addisorder tre ent/dischard ug test resu d goals/trea esychiatric in ds: Grades r records, w | atment reco ge summary ilts tment plans nformation/l , Attendanc rhich may ir | / Mental health evaluation e, Behavior (if applicable) | | |
| This authorization will event, or condition note | | | | | a different specification of date, | | |
| expiration or revocation of this health information. In addition syndrome (AIDS), human immodifications. I understand that records/information is not a higher bedisclosed and no longer requesting that any and all sufficient to the protected health information revocation to the party named | ne release of my medicals authorization. The Property is authorization. The Property is authorization. The Property is authorized by the sealth care provider or he protected by those regular protected records be into be disclosed. 4) If above. If I revoke this envices if I refuse to constitution. | al/health intotected Heation relate IV), and/or s authoriza ealth plan culations. 3 e released may revolute authorizat sent to a dis | formation, whe alth Information other commu- tion. 2) If the covered by fect Ocertain reconunder this authoria ion, it will have sclosure for pu | other past, preson in my medic ransmitted dis- nicable disease person or entit deral privacy re- rds may be pro- norization. I my eation at any tire or no effect on a proses of trea | sent, or in the future up to the date of al record includes mental/behavioral eases, acquired immunodeficiency es or environmental diseases and y that receives the described equiations, the records/information may dected by federal or state law and I am ay request to inspect or obtain a copy of the by delivering/mailing a written actions already taken on reliance on this tment, payment, or healthcare | | |
| | act on behalf of the c | lient as th | ne client's pe | | nderstand this form. I am the client sentative. I also permit disclosure of | | |
| Client Signature | | | | | Date | | |
| Guardian/Representativ | /e Signature | | Author | ity | Date | | |
| (Please include a description of a | uthority to act on Client's b | ehalf and att | lach a copy of th | e document grar | nting authority, where applicable.) | | |
| If you would like a copy of | of this authorization, | please ini | tial here | No сору у | vill be provided if not initialed. | | |

PREFERRED FAMILY HEALTHCARE, INC. AUTHORIZATION FOR DISCLOSURE

| Client/Patient Full Nam | e: | | | Date of Birth: |
|---|--|---|---|--|
| Authorizes PREFERRE | FAMILY HEALTHC | ARE, INC. to comm | nunicate with | , disclose to and obtain from: |
| Name/Entity: Address: City/State/Zip: | | | | |
| Phone: Purpose of Disclosure: | Continuity of Care Other: | Legal Insurance | Research | Individual's Request |
| The following information All records, which work Intake assessment Medication history Progress notes/ case Immunization records Physical health inform Employment Verifica Vocational Information STD testing, whether communicable, non-congonorrhea, HIV, or AID | will include all of the Acknow Substante notes Dates of U.A. or mation Progression Psycholon Education negative or positive mmunicable, or ven | he below vledgement of my a nce use disorder tr of treatment/discha other drug test res as toward goals/tre logical/Psychiatric ion records: Grade re, and/or records, | eatment reco rge summary ults atment plans information/l s, Attendanc which may ir | y Mental health evaluation ee, Behavior (if applicable) |
| event, or condition notes I understand the following: authorization, I am allowing the expiration or revocation of this health information. In additional syndrome (AIDS), human immodifications. I understand that records/information is not a higher equesting that any and all suffice the protected health information revocation to the party name form. 5) I might be denied see | automatically expired. | oformation records are of al/health information, who tected Health Information related to sexually IV), and/or other comm is authorization. 2) If the ealth plan covered by feulations. 3) Certain recovered explain recovered by the control of the authorization, it will have the a disclosure for present the authorization, it will have the authorization of the authorization. | confidential. I use there past, preson in my medic transmitted discurricable disease person or entitiederal privacy reords may be prothorization. I mization at any time no effect on a purposes of treas | nderstand that by signing this sent, or in the future up to the date of cal record includes mental/behavioral eases, acquired immunodeficiency es or environmental diseases and ty that receives the described egulations, the records/information may blected by federal or state law and I am nay request to inspect or obtain a copy of me by delivering/mailing a written actions already taken on reliance on this utment, payment, or healthcare |
| | of the records/informa | ation described. I ha lient as the client's p | ve read and u | nderstand this form. I am the client sentative. I also permit disclosure of |
| Client Signature | | | <u> </u> | Date |
| Guardian/Representativ | ve Signature | Autho | rity | Date |
| | | | | nting authority, where applicable.) |
| If you would like a copy of | of this authorization, | please initial here | No copy v | will be provided if not initialed. |





| Name: | DOB: |
|-------|------|

Late/No-Show Policy

Thank you for trusting your care to Preferred Family Healthcare/Clarity. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our policy below.

A patient is considered to be Late if they arrive 15 minutes after their appointment time.

A patient is considered a **No-Show** if they **fail to keep their scheduled appointment** without calling at least **24 hours** in advance.

If a patient misses <u>3 appointments in one year</u>, they may be <u>suspended</u> from the practice for 1 year or be restricted to same-day only appointments. Should the patient be suspended, all upcoming appointments will be cancelled.

If the patient arrives more than 15 minutes past their appointment time it is at the discretion of the provider/manager as to whether the patient will be rescheduled for another day/lime or worked into the schedule. Patients who arrive late may not receive their full treatment.

In order to help our patients remember to keep their appointments, a courtesy reminder call will be made at least one business day before the appointment. A voicemail may be left. If you do not receive a reminder call or message, the above policy will remain in effect.

The Late/No-Show Policy for Patients enrolled in the Addiction Medication Program may differ. Please refer to your AMP Program manual for details.

Medication Refill Policy

Our office handles a large volume of daily prescription refill requests. In order to ensure that prescriptions are filled accurately and efficiently, we have implemented the following medication refill policy.

Medication refill requests must be called in at least <u>3 business days</u> in advance. Requests received on Friday may not be addressed until Monday or Tuesday of the following week.

I acknowledge that I have read and understand the Late/No-Show and Medication Refill Policies.
I understand that failure to comply with these policies could lead to suspension of services.

Referral for Services (***Illinois only)

I authorize Clarity Healthcare and their community partners to exchange demographic, medical and social information through the HIPAA compliant integrated Referral and Intake System (IRIS) for the purpose of serving my family.

| Patlent Signature: | Date; |
|---------------------------------------|---------------------------|
| Legal Guardian Signature: | Date: |
| Relationship to patient: Parent Legal | Guardian Other (specify): |



Declaration of Limited Income

| Date: | | |
|-------------|---------------------------------|--|
| | over any portion of my services | certify that I have limited here at Clarity Healthcare. |
| Address: | | |
| City: | State: | Zip: |
| Signature: | | |
| Print Name: | | |

This is good for 90 days from the date on the form.

Re-evaluation can be completed after 90 days.



CLARITY HEALTHCARE APPLICATION FOR SLIDING SCALE

| Name | | | | | |
|---------------------------------|------------------|-----------------------|---------------------|---------------------|----------|
| Birth Date | | SSN | | | |
| Address | | | | | |
| Phone # | | | | | |
| Marital Status (circle one): | Single | Married | Separated | Widowed | Divorced |
| Employment Status (circle one): | Employed | Unemployed | Retired | Disabled | |
| List all members of the househo | old; include all | persons living in tha | t household (relate | ed or non-related). | |
| Na | me | | | Relationship | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Sources of Income

- Wages (W2's, Tax Returns, letter from employer, other)
- Gross Wages/Salaries/Tips
- Unemployment Compensation
- Worker's Compensation
- Earnings from need-based employment programs
- Welfare Benefits
- Social Security
- · Supplemental Security Income
- Survivor's Benefits
- Pensions
- Veteran's Benefits
- Regular Contributions from persons not living in household
- Any other income not included in the above list

All Sliding Fees Are Due at Time of Service

Signature needed on Page 2

Updated 07/01/2021

Medical Services

Slide A-\$20 per Visit

Slide B-\$25 per Visit

Slide C-\$30 per Visit

Slide D-\$35 per Visit

Slide E-\$40 per Visit

Behavioral Health Services

Evaluation and Medication Management:

Slide A-\$20 per Visit

Slide B-\$25 per Visit

Slide C-\$30 per Visit

Slide D-\$35 per Visit

Slide E-\$40 per Visit

Therapy Services

\$10 on all Slide levels

Dental Services

Initial Assessment-\$15 for All Slide Levels

Dental Procedures:

Slide A-30% of Charges

Slide B-40% of Charges

Slide C-50% of Charges

Slide D-60% of Charges

Slide E-70% of Charges

Some services are not included in the sliding fee program

All Sliding Fees Are Due at Time of Service

I have read and completed this form and ensured that the information I entered is true and complete to the best of my knowledge. I understand completion of this form does not guarantee a discount, and if I do not qualify for a discount I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform Clarity Healthcare with current documentation of my financial status at my next visit. All Information submitted will remain confidential. I understand that if I qualify for the sliding scale program, the minimum due could be a payment of \$20 per appointment.

| Signature of Applicant | | |
|-------------------------------|------|--|
| | Date | |
| Total Annual Household Income | | |
| Approved Sliding Scale Amount | | |
| Employee Signature | | |

Slide Expires on 06/30/2022