Clarity Healthcare

Preferred Family Healthcare

(Please Print)

Today's Date:	Primary Care Provider:		
Patient Information			
Patient Name (Last, First, Middle):	Mr. Ms. Mrs. Miss	Former Name(s):	
Is this your legal name? Yes No	If not, what is your legal name?		
Sex: Male Female Other	DOB:	Age:	Social Security #:
Primary Phone #:	Secondary Phone #:	Email Address:	
Street Address:		P.O. Box:	
City:	State:	ZIP Code:	
Patient Occupation:	Patient Employer:	Employer Phone #:	
School Currently Attending (If Child):	Does child receive free/reduced lunches: Yes No NA		
Spouse/Guardian/Parent Information:	Address:	Phone #:	
Name:			
Guardian/Parent Information:	Address:	Phone #:	
Name:			
Insurance Information (Please give your insurance card to the receptionist)			
Person Responsible for Bill:	Birth Date:	Address (If different):	Primary Phone #:
Is this person a patient here? Yes No	Patient relationship to subscriber: Self Spouse Child Step-Child Other		
Occupation:	Employer:	Employer Address:	Employer Phone #:
Primary Insurance: Medicare Medicaid Blue Cross Blue Shield United Healthcare Other:_____			
Subscriber Name:	Subscriber SSN:	Birth Date:	Co-Payment:
	Policy #:	Group #:	$
Secondary Insurance (if applicable):	Subscriber Name:	Policy #:	
		Group #:	
Patient relationship to subscriber: Self Spouse Child Step-Child Other			
In Case of Emergency			
Name of local friend or relative (not living at the same address):		Relationship to patient:	
Primary Phone #:	Secondary Phone #:		

Clarity Healthcare

Preferred Family Healthcare

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 each of the following categories:

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race:
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Alaska Native
☐ White (not Hispanic or Latino)
☐ Hispanic or Latino (all races)
☐ Decline to Disclose

Primary Language:
☐ English
☐ Other (Specify):_____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated

Are you a Veteran?
☐ Yes ☐ No

Gender Identity:
☐ Male
☐ Female
☐ Transgender (Female to Male)
☐ Transgender (Male to Female)
☐ Other
☐ Decline to Disclose

Housing Status:
☐ Own/Rent
☐ Homeless
☐ Transitional
☐ Doubling Up
☐ Shelter
☐ Permanent Supportive

Sexual Orientation:
☐ Straight
☐ Bisexual
☐ Lesbian/Gay
☐ Don't Know
☐ Decline to Disclose

Employment Status:
Patient:
☐ Part ☐ Full ☐ Unemployed
☐ Migrant ☐ Seasonal
Spouse:
☐ Part ☐ Full ☐ Unemployed
☐ Migrant ☐ Seasonal

How did you hear about Preferred Family Healthcare/Clarity?
☐ Referral (Friend/Family) ☐ Referral(Physician) ☐ Billboard ☐ Magazine
☐ Newspaper ☐ Social Media ☐ Health Fair ☐ Other
(Specify):_____

Advance Directives:
Do you have an Advance Directive? ☐ Yes ☐ No
If yes, who is your health care agent? _____

Family Members: For the protection of your confidentiality, do you have any family members who work at Preferred Family Healthcare/Clarity? ☐ Yes ☐ No If yes, who?_____

List ALL members of the household. Include all persons living in the household (related or non-related):

Name:	Relationship:

Sources of Income:

- ☐ 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 person not living in the household
- ☐ Any other income not included in the above list

Total Annual Household Income: **$**

I 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 if 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, you qualify for ____ on the sliding fee scale and will be charged $ _____ per ☐ visit ☐ month.

Clarity Healthcare

Preferred Family Healthcare

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:		**Illinois:**
•United States Probation & Pretrial Services Western District of Missouri	*•St. Louis Mental Health Board*	*•Adams County Probation*
•Community & Children's Resource Board of St. Charles County	*•Missouri Foundation for Health*	*•Pike County Probation*
•Franklin County Children & Families Community Resource Board	*•Missouri Department of Mental Health*	
•State of Missouri Department of Social Services	*•Office of State Courts Administrator*	**Kansas:**
•Children's Services Fund of Jackson County	*•12th/45th Circuit Treatment Court*	*•United Community Services of Johnson County*
•Jordan Valley Community Health Center	*•9th/41st Circuit Treatment/Drug Court*	
•St. Louis County Children's Service Fund	*•Community Foundation of the Ozarks*	

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.

Confidentiality Practices: 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.

Photo Consent: 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.

Medical and Psychiatric Advance Directives: 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:

| **Exercise:** Some Preferred Family Healthcare/Clarity programs include recreation and physical exercise. I consent to participate in these activities at my own risk. I understand Preferred Family Healthcare/Clarity and its representatives shall not be liable for any claims arising out of participation. If there is a reason I cannot participate, I understand it is my responsibility to notify program staff.

| **A.R.T. - C:** I understand I may be given opportunities to participate in the Achieving Recovery Through Creativity (A.R.T.-C) program throughout treatment. I hereby assign, transfer and convey all of my right title and interest in any art I create, in whole or in part, during my participation, to Preferred Family Healthcare/Clarity. I understand photographs and reproductions of my projects may be used as marketing and fundraising materials including but not limited to brochures, newspapers, posters and cards. I understand no additional consideration will be owed to me for any of these purposes.

| **Public/Media Opportunities:** I understand I may be given opportunities to participate in public contests, shows or community activities which may result in photographs and/or press articles. I may also be given opportunities to be interviewed, photographed and/or videotaped to share my personal story or experiences with Preferred Family Healthcare/Clarity, for the purpose of creating educational or marketing materials, which may then be distributed broadly throughout the community. Participation in the above-mentioned opportunities may disclose personal information to the public such as my name and hometown as well as my involvement in treatment. Once materials are distributed, there is no guarantee the information will not be picked up by the media or be posted on the internet. Preferred Family Healthcare/Clarity, it's affiliates, and employees are not legally responsible or liable for the re-disclosure of the information. I understand these opportunities are in no way mandatory and my voluntary agreement and participation constitutes implicit consent.

| **Telehealth:** I understand there may be services available to me through participation in Telehealth and that participation in these services is not mandatory and I will be informed of alternative resources for needed care. I can refuse to participate in Telehealth services at any time without affecting my right to future care through Preferred Family Healthcare/Clarity. Telehealth services are subject to the same confidentiality laws as services provided in person and there will be no dissemination, storage, or retention of video interaction produced during Telehealth services. I will be informed of all parties who are present during the Telehealth service and I have the right to exclude anyone at my request. I will be provided with emergency contact information should a mental health or medical emergency arise.

| **Alternative Communication Methods:** Preferred Family Healthcare/Clarity will at times need to communicate with me about my protected health information, the care I receive, my bill, and other services. These communications may include, but are not limited to, refill and appointment reminders, scheduling requests, and referrals. I understand Preferred Family Healthcare/Clarity may contract with other organizations to manage or collect for the services provided to me. This consent extends to telephone communications by these organizations as well. I understand that use of wireless telephone and email may increase the risk of inadvertent or unauthorized disclosure of my information to third parties. I understand I am responsible for protecting any information I receive and consent to receive communication through the following **(Please Indicate)**: ☐ **Phone call** ☐ **Text Message** ☐ **Email** ☐ **All**

I have read and understand the above. I have been informed and understand the nature of the services provided by Preferred Family Healthcare/Clarity and my right to request discharge if at any time I do not wish to continue services and treatment.

Patient Signature:_____ Date:_____

Legal Guardian Signature:_____ Date:_____

Relationship to patient: Parent Legal Guardian Other (specify):_____

Clarity Healthcare

Preferred Family Healthcare

Would you like a copy? ☐ Yes ☐ No

PREFERRED FAMILY HEALTHCARE, INC.
AUTHORIZATION FOR DISCLOSURE

Client/Patient Full Name:_____ Date of Birth:_____

Authorizes **PREFERRED FAMILY HEALTHCARE, INC.** to communicate with, disclose to and obtain from:

Name/Entity: _____
Address: _____
City/State/Zip: _____
Phone: _____
Purpose of Disclosure: Continuity of Care Legal Insurance Research Individual's Request
Other:_____

The following information contained in my health record:

☐**All records, which will include all of the below**

☐Intake assessment
☐Medication history
☐Progress notes/ case notes
☐Immunization records
☐Physical health information
☐Employment Verification
☐Vocational Information
☐Acknowledgement of my admission and/or program participation
☐Substance use disorder treatment records
☐Dates of treatment/discharge summary
☐U.A. or other drug test results
☐Progress toward goals/treatment plans
☐Psychological/Psychiatric information/Mental health evaluation
☐Education records: Grades, Attendance, Behavior (if applicable)

☐STD testing, whether negative or positive, and/or records, which may indicate the presence of communicable, non-communicable, or venereal disease (including but not limited to hepatitis, syphilis, gonorrhea, HIV, or AIDS)

☐Other (please list):_____

This authorization will automatically expire in one year unless there is a different specification of date, event, or condition noted._____.

I understand the following: 1) My medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information, whether past, present, or in the future up to the date of expiration or revocation of this authorization. The Protected Health Information in my medical record includes mental/behavioral health information. In addition, it may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other communicable diseases or environmental diseases and conditions. I understand that I may refuse to sign this authorization. 2) If the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. 3) Certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization. I may request to inspect or obtain a copy of the protected health information to be disclosed. 4) I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party named above. If I revoke this authorization, it will have *no* effect on actions already taken on reliance on this form. 5) I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, as permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the client listed or am authorized to act on behalf of the client as the client's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____
Client Signature Date

_____
Guardian/Representative Signature Authority Date

(Please include a description of authority to act on Client's behalf and attach a copy of the document granting authority, where applicable.)

If you would like a copy of this authorization, please initial here____. No copy will be provided if not initialed.

PREFERRED FAMILY HEALTHCARE, INC.
AUTHORIZATION FOR DISCLOSURE

Client/Patient Full Name:_____ Date of Birth:_____

Authorizes **PREFERRED FAMILY HEALTHCARE, INC.** to communicate with, disclose to and obtain from:

Name/Entity: _____
Address: _____
City/State/Zip: _____
Phone: _____
Purpose of Disclosure: Continuity of Care Legal Insurance Research Individual's Request
Other:_____

The following information contained in my health record:

☐**All records, which will include all of the below**

☐Intake assessment ☐Acknowledgement of my admission and/or program participation
☐Medication history ☐Substance use disorder treatment records
☐Progress notes/ case notes ☐Dates of treatment/discharge summary
☐Immunization records ☐U.A. or other drug test results
☐Physical health information ☐Progress toward goals/treatment plans
☐Employment Verification ☐Psychological/Psychiatric information/Mental health evaluation
☐Vocational Information ☐Education records: Grades, Attendance, Behavior (if applicable)
☐STD testing, whether negative or positive, and/or records, which may indicate the presence of communicable, non-communicable, or venereal disease (including but not limited to hepatitis, syphilis, gonorrhea, HIV, or AIDS)
☐Other (please list):_____

This authorization will automatically expire in one year unless there is a different specification of date, event, or condition noted._____.

I understand the following: 1) My medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information, whether past, present, or in the future up to the date of expiration or revocation of this authorization. The Protected Health Information in my medical record includes mental/behavioral health information. In addition, it may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other communicable diseases or environmental diseases and conditions. I understand that I may refuse to sign this authorization. 2) If the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. 3) Certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization. I may request to inspect or obtain a copy of the protected health information to be disclosed. 4) I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party named above. If I revoke this authorization, it will have *no* effect on actions already taken on reliance on this form. 5) I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, as permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the client listed or am authorized to act on behalf of the client as the client's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____
Client Signature Date

_____
Guardian/Representative Signature Authority Date

(Please include a description of authority to act on Client's behalf and attach a copy of the document granting authority, where applicable.)

If you would like a copy of this authorization, please initial here____. No copy will be provided if not initialed.

Clarity Healthcare

Preferred Family Healthcare

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 3 appointments in one year, they may be suspended 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/time 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 3 business days 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.

Patient Signature:_____ Date:_____

Legal Guardian Signature:_____ Date:_____

Relationship to patient: Parent Legal Guardian Other (specify):_____

Updated 11/2021

Declaration of Limited Income

Date: _____

I, _____ certify that I have limited income and I am unable to cover any portion of my services 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 household; include all persons living in that household (related or non-related).

Name	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

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