INCOME AND INSURANCE INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /

PAYMENT POLICY

- Payment of co-pays and certain other fees are expected at time of service.
- Uninsured patients are also expected to pay appropriate fees at time of service.
- It is your responsibility to notify Avenue 360 Health & Wellness of any insurance carrier changes.
- If you have either Medicaid and/or Medicare the charges for your visit and the services received will be submitted to Medicaid and/or Medicare for reimbursement to the clinic.
- If you have submitted an application for Medicaid and/or Medicare you will be responsible for the full amount of the charges until your application is approved.

INSURANCE INFORMATION

Is this patient covered by the Insurance being presented? □ Yes □ No (If you checked "No", please skip this section).
The insurance being presented is coverage for? (Please Check one that applies): □ Medical □ Dental or □ Both
Please indicate Primary Insurance:
□ Private □ Medicaid □ Medicare □ CHIP □ CHIP Perinatal □ other:_____

Secondary Insurance (if applicable):
□ Private □ Medicaid □ Medicare □ CHIP □ CHIP Perinatal □ other:_____

Person Responsible for charges:

NAME	ADDRESS	PHONE NUMBER

INSURANCE PLAN	POLICY NUMBER	GROUP NUMBER

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ other

GROSS INCOME In order to provide correct sliding fee scale class, we will need evidence of your most recent financial income.

Monthly Gross Income: (Please enter income earned before taxes are deducted):	Household Size:

(Please Check one that applies):
□ If you are employed and are unable to provide proper documentation of income resources, complete the information below
I, _____ (your name) am employed and my income per month is an average, approximately $_____.

□ If you are self-employed, complete the information below
I, _____(your name) am self-employed and my income per month is an average, approximately $ _____.

□ If you are un-employed or no one supports you, complete the information below.
I, _____ (your name) am un-employed and have no supporter and my income per month is $ _____.

DISCOUNT FEE PROGRAM

- I understand that Avenue 360 Health & Wellness offers a sliding fee schedule to discount the cost of medical or dental care for individuals and families that meet financial eligibility criteria. It is my responsibility to provide Avenue 360 Health & Wellness with the appropriate financial documentation requested to determine my eligibility for this discount program.
- Also, I understand that I must re-apply for the discount program each year, or sooner if my household income or family size changes.
- I attest that the information provided on this form is accurate and any findings by Avenue 360 of false statements may result in full payment of all rendered and future services.

I HAVE READ AND UNDERSTAND THE PAYMENT OPTIONS POLICY

Patient Signature: _____ Date: _____

For Minors:
Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Registration Staff Signature:_____ Date: _____