Introduction to the New Pediatric Patient Packet

Thank you so much for your interest in becoming a new patient at Island Health Care! We are excited to have you join our practice. Here's a quick description of the forms contained in this packet. The first few forms are required for us to get your pediatric patient in our system and scheduled for their first appointment!

- **Form 1 "Pediatric Patient Registration":** This form includes the basic information that we need to get a patient set up in our system. We need contact information for at least one parent or legal guardian.
- **Form 2 "IHC Consent for Treatment":** We need parental/guardian consent to provide care to the pediatric patient at Island Health Care.
- **Form 3 "Acknowledgement of Receipt of Notice of Privacy Practices":** We are required to provide you with this notice to help you understand how we may use or share your information from your designated record set. Please read through this and sign the form to confirm that you have received and reviewed the Notice.
- **Notice of Patients' Rights:** We are required to provide you with this notice to help you understand your rights as a patient of this Health Center.

The remaining forms in this packet are ***optional***. Please review the purpose of each form to decide whether you'd like to fill one out.

- **Form 4 "Proxy Consent to Treat Minors":** This allows you to designate individuals other than the minor patient's parent or legal guardian to consent to their medical care and attend appointments with them. This authorization can be given for one specific appointment, for a specific date range, or for one year.
- **Form 5 "Authorization to Treat Unaccompanied Minor":** This form allows a minor patient's parent/legal guardian to authorize IHC to see the minor patient even if the parent/legal guardian does not accompany the minor patient to the appointment.
- **Form 6 "Island Health Care Sliding Fee Application":** As a Federally Qualified Health Center (FQHC), Island Health Care provides a sliding fee discount to patients who are income eligible. Even if you have insurance, you may still be eligible for a sliding fee. To determine if you are eligible for this discount you will need to fill out and sign this application. Our outreach and enrollment coordinator will then reach out to you to help finalize your application and determine whether you are eligible.

Please note that in order to make Island Health Care your primary care provider (PCP), you may need to contact your insurance company to notify them IN ADVANCE of your first visit and make any changes.

Please bring this completed packet to the Island Health Care Clinic at 245 Edgartown Vineyard Haven Road. Please also bring the following items if you have them:

- **Photo ID**
- **Insurance card**
- **Vaccination/ Immunization Records**
    - *If you can't bring your immunization records in with your paperwork, please make every effort to bring them to the clinic before your first appointment.*

PLEASE SIGN UP FOR MYCHART: The patient portal offered by Epic, IHC's Electronic Health Record, is called MyChart. It allows you and your chosen caregivers to easily access your health information, communicate with your IHC care team, request prescription refills, view your immunization records, quickly access test results, and pay bills using an app or webpage on your phone or computer. As part of the new patient registration process, we will ask you if you'd like to register for a MyChart account. We strongly encourage every patient to do so. If you have any questions, just ask!

Island Health Care
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Medical Record #

(For office use only)

Pediatric Patient Registration

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order

Patient's Legal Name (Printed)	Last	First	Middle	**Name used** (if different):
Legal Sex (please check one)* **( )** Female **( )** Male **While Island Heath Care (IHC) recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and gender reference are different from these, please let us know in the space to the right.*				**Preferred** (if different):
Date of Birth *Month Day Year* / /			**Social Security #**	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) __OK to leave a voice message	**Cell Phone** ( ) __ OK to text or voice message	**Best number to reach you:** _____Home__Cell	
Mailing Address (P.O. Box if you have one)	City	State	ZIP
Patient's email address (if 12 or older for MyChart access):		**Student?** ❑ Full Time ❑ Part Time ❑ Not a student	
If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.			
Parent/Guardian 1 Name:	Phone Number		Relationship to patient
Parent/Guardian 1 Mailing Address (P.O. Box if you have one)	City	State	ZIP
Parent/Guardian 2 Name	Phone Number		Relationship to patient
Parent/Guardian 2 Mailing Address (P.O. Box if you have one)	City	State	ZIP

This information is for demographic purposes only, without personal identifiers and does not affect your care.

1.) What is your family's annual income? $ ❑ No income **2.) How many people (including you) does that income support?** # _____	**3.) Preferred Language (choose one)** ❑ English ❑ Español ❑ Português ❑ Other _____	**4.) Racial Group(s) (check all that apply)** ❑ African--American / Black ❑ Asian ❑ Brazilian/African--American Black ❑ Brazilian / White ❑ Caucasian / White ❑ Native American / Alaskan Native / Inuit ❑ Pacific Islander ❑ Other _____	**5.) Ethnicity** ❑ Hispanic/Latino/Latina ❑ Not Hispanic/Latino/Latina ❑ Brazilian/Not Hispanic **6.) What is your gender?** ☐ Female ☐ Male ☐ Genderqueer or not exclusively male or female
7.) What was your sex assigned at birth? ☐ Female ☐ Male **8.) Do you think of yourself as:** ❑ Lesbian, gay, or homosexual ❑ Straight / heterosexual ❑ Bisexual ❑ Something else ❑ Don't know	**9.) Do you identify as transgender or transsexual?** ☐ No ☐ Yes – Male to Female ☐ Yes – Female to Male ☐ Yes – Non-binary ☐ Don't know **10.) Are you a seasonal farm worker?** ❑ Yes ❑ No	**11.) Marital Status** ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Other_ **12.) Housing Status** ❑ Rent ❑ Public housing? ❑ Is rent based on income? ❑ Own home ❑ Living in transitional housing ❑ Homeless or homeless shelter	**13.) Referral Source (how did you hear about us?)** ❑ Self ❑ Friend or Family Member ❑ Health Provider ❑ Emergency Room ❑ Ad/Internet/Media ❑ Outreach Worker ❑ School ❑ Other _____

Please provide insurance card(s) to front desk staff

Primary Insurer: _____	**Secondary Insurer:** _____
Subscriber Name: _____	**Subscriber Name:** _____
Relationship to Patient: _____	**Relationship to Patient:** _____
Subscriber SSN: _____ - _____ - _____	**Subscriber SSN:** _____ - _____ - _____
Date of Birth (MM/DD/YYYY): ____ /_____ /_____	**Date of Birth (MM/DD/YYYY):** ____ /_____ /_____

The person signing this form will be noted in our records as the Guarantor of the account. As such s/he will receive financial statements from our office. Both parents/legal guardians are responsible for any financial balance although we will normally contact Guarantor first.

Financial Agreement: I understand that I am financially responsible for all charges for services provided to me or my dependent children, including the balance remaining after payment of possible insurance benefits according to the terms of my insurer's contract with Island Health Care.

Assignment of Benefits: I request that payment of authorized medical benefits be made on my behalf directly to Island Health Care for services rendered. I authorize any holder of medical information about me to release to the state and/or federal administration(s) and its agents or other insurer, any information needed to determine these benefits payable for related services. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Agreement is to be considered as valid as the original.

Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

Island Health Care – Consent for Treatment

Patient Name_____ Date of Birth: _____
(Printed) MM/DD/YYYY

I hereby give my consent and authorize Island Health Care to treat any medical condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously.

I understand that Island Health Care operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Island Health Care may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I may request a copy of IHC Patient Rights and Grievance Resolution process.

I certify that the above information is true and correct.

Parent/Legal Guardian Signature:_____ Date: _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Island Health Care
Community Health Center

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Island Health Care Community Health Center
245 Edgartown Vineyard Haven Road
Edgartown MA 02539

Privacy Officer: Priya Esposito
Phone: 339-205-3968
Email: pesposito@ihimv.org

Effective 03/22/2023

Island Health Care
A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____

Mailing Address: _____

I have been given a copy of Island Health Care's *Notice of Privacy Practices ("Notice"*), which describes how my health information is used and shared. I understand that Island Health Care has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Island Health Care Privacy Official, or by visiting the Island Health Care web site at www.ihimv.org.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name

_____
Personal Representative's Title if Not Parent or Legal Guardian (e.g. Health Care Power of Attorney)

For Island Health Care Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

_____

Completed by:

_____ _____
Signature of Island Health Care Representative Date

_____
Print Name

AS A PATIENT OF THIS COMMUNITY HEALTH CENTER,

YOU HAVE THE RIGHT TO:

1. Choose your doctor or nurse
2. Get a bill with a list of charges
3. Know the names and jobs of the people who take care of you
4. Have your records seen only by your doctor or nurse
5. Get an answer quickly when you ask something
6. Know how we work with other places to take care of you
7. Get a copy of our patient rules
8. Know about free and low cost health care
9. See your records and get a copy of them
10. Say no to having students or observers help take care of you
11. Say no to being in research or education projects
12. Be alone with your doctor or nurse when they treat you
13. Be treated right away if you might die, even if you don't have insurance or cannot pay
14. Know the facts about any test or treatment before you say yes to it
15. Get copies of bills we send to other places that take care of you
16. Know how your doctor works with the other places that take care of you—including if he or she is paid by them
17. Get copies of bills to or payments from your insurer or health care program
18. For patients with breast cancer, to be told about all the ways it can be treated
19. For patients getting breast implants, to be told about all the risks
20. For women having a baby, to know the facts about all the things we may do during labor and birth
21. Get help with pain

The above is a summary of Massachusetts General Law, Title XVI, Chapter 111, Section 70E, Patients' and Residents' Rights. For a copy of the complete law, ask the receptionist.

MASSACHUSETTS LEAGUE
OF COMMUNITY HEALTH CENTERS

2006

Island Health Care
A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

PROXY CONSENT TO TREAT MINORS

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at Island Health Care Community Health Center (IHC). For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent or to accompany the minor. If you would like to appoint proxy decision maker, please review and complete the following form authorizing a proxy decision-maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

AUTHORIZATION:

I hereby appoint _____ _____ _____

NAME RELATIONSHIP Best Contact Phone

as a proxy decision maker to consent to and authorize routine health care, treatment and services for my child(ren) listed below.

Routine medical care and interventions may include, but are not limited to: Medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses). IHC ay also give immunizations, allergy shots and intramuscular/intravenous antibiotics pursuant to the consent of the proxy.

I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child(ren) listed below, and to receive protected health information directly relevant to and for the purposes of, his or her involvement in this care or payment related to this care. More than one child may be listed.

Name of Minor and Date of Birth (MM/DD/YYYY): _____
Name of Minor and Date of Birth (MM/DD/YYYY): _____

LIMITATIONS:

Identify and specific limitations on the kinds of medical services for which this authorization is given (if none, specify “none”).

_____

The authorization is valid for (check one):

- Today’s visit only
- From _____ / _____ / _____ to _____ / _____ / _____ (dates in MM/DD/YYYY format)
- Until revoked in writing by me

By default, this consent will be valid for one year from today’s date unless otherwise specified in writing.

I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed d above) is permitted to make decisions on consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. Only one parent’s signature is required.

Parent/Legal Guardian Name (**print**) _____

Parent/Legal Guardian Name (**sign**) _____

Date (MM/DD/YYYY): _____ / _____ / _____

Island Health Care
A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

AUTHORIZATION TO TREAT UNACCOMPANIED MINOR

Minor patients **between the ages of 14 and 18** may be seen by their Island Health Care provider even if they're not accompanied by a parent, legal guardian, or designated proxy, so long as their parent or legal guardian has completed this form.

Patient's Name: _____ Patient's DOB: _____

I, the undersigned, herby authorize Jenna Larson, NP, and whomever she may designate as an assistant, to administer such treatment as is necessary for the above named patient. I hereby certify that I have read and fully understand this authorization.

The authorization is valid for (check one):

- Today's visit only
- From _____ / _____ / _____ to _____ / _____ / _____ (dates in MM/DD/YYYY format)
- Until revoked in writing by me

This consent will be valid for one year from the date unless otherwise specified in writing.

Waiver of Liability for all clients at every visit

I understand I have the responsibility to ensure payment for the care and services my minor child receives from Island Health Care. Furthermore, I understand that I will be responsible for the payment of any and all services rendered, whether or not I have verified my care benefits. I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization.

Parent/Legal Guardian Name (print) _____

Parent/Legal Guardian Name (sign) _____

Date: _____ / _____ / _____ (MM/DD/YYYY)

Island Health Care

Island Health Care Sliding Fee Discount Application

How Does the Sliding Fee Scale Work?

As a Federally Qualified Health Center (FQHC), Island Health Care provides a sliding fee discount to patients who are income eligible. Even if you have insurance, you may still be eligible for a sliding fee. To determine if you are eligible for this discount you will need to fill out and sign this application. In addition to this application, you will need to provide IHC with the following documents to apply for the sliding fee discount:

Proof of income for you and any family household members. The following items may be used as proof of income:

- Two most recent pay stubs
- Most recent income tax returns with attached W-2s and/or 1099s
- Employer letter: For those not receiving an actual paycheck, a letter from your employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that the information can be verified.
- Any other income documentation (i.e. statement of unemployment benefits, social security benefit letter, public assistance benefits letter, etc.)
- Self-declaration of zero income (see bottom of page 2)

Please attach copies of all documents or self-declaration statements being used as proof of income. **If you need help filling out this form or have any questions, please call our Outreach & Enrollment Coordinator, Keira Peters at (339) 240-3918.**

NOTE: Under federal regulations, in order to provide you with a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. Your annual income and your family size will be used to calculate your discount. You must verify your income every year. IHC conducts all annual sliding fee renewals in April, because it is easier for patients to get their income verification documents during tax season. Please remember to hold on to your tax documents in April, and IHC will be in touch to renew your eligibility for the sliding fee program!

Applicant's Full Name (first, middle, last):	Today's Date:
Mailing Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code:	Primary Phone Number (best number to reach you at):

Are you covered by or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefit, Medicaid (MassHealth), and/or Medicare? ☐YES ☐NO

Island Health Care

If yes, please provide the following information:

Policy Holder (Full Name):_____ Insurer:_____
Policy Number:_____

Family Household Members & Gross Income (ex. dependent children, spouse/partner).

Proper proof of income documents must be provided for each family household member.

Number of immediate family members in household: _____ *Please list each household member below:*

Name	Date of Birth	Relationship	Employed?	Annual Income
			Yes / No	$
			Yes / No	$
			Yes / No	$
			Yes / No	$
			Yes / No	$
TOTAL FAMILY HOUSEHOLD INCOME (add the annual income of each household member together):				$

I certify that the information provided is accurate to the best of my knowledge, and that if I pay a discounted fee for today's visit, **I will provide the required documentation to IHC within 14 days** or by the time of my next visit, whichever is sooner**. If upon review IHC determines that I am NOT eligible for a discount or I fail to submit the required follow-up documentation, I agree that I am responsible for the non-discounted fee for today's visit.** I understand that I will be asked to update this information on annual basis. I understand I am fully responsible for my bill if I do not comply with the above requirements.

_____ _____ _____
Full Name (Print) Signature Today's Date

IF YOU HAVE NO INCOME, PLEASE FILL OUT ALL OF THE FOLLOWING QUESTIONS TO QUALIFY FOR A DISCOUNT:

Name of last employer: _____ Date of last employment: _____
Income earned so far this year: $_____ Do you expect to become employed? YES / NO
If YES, when?: _____ If YES, your expected weekly income will be: $_____
Please explain how your basic needs have been met: (i.e. How do you pay for…)

- Food: _____
- Utilities: _____
- Shelter: _____
- Non-Food Items: _____

I, _____, certify that I have had no source of income since_____.