clarity child guidance center

Patient Financial Application

SECTION I- PATIENT PROFILE

Patient's Name: _____ Date of Birth ___/___/___ Sex: _____

Address:_____City:_____State:_____Zip: _____

Social Security #:_____-_____-_____ Home Telephone# (____)_____-_____ Cell#: (_____)_____-_____

Parent/Legal Guardian: _____

Address (if different than patient):_____City:_____State:_____Zip: _____

Job Title:_____ Social Security #:_____-_____-_____

Employer:_____Employer's Address _____

SECTION II—INCOMES

Complete this section if you want to be considered for reduced fees based on our sliding fee scale or to discuss payment arrangements.

Gross Monthly Income for Household Members

Amount	Source
	Total

Circle one:

YES **NO** My child receives Social Security benefits, child support or other sources of income that are not paid directly to or controlled by the child.

If **YES:** $Amount_____Source_____Circle one: Daily Weekly Monthly

YES **NO** My child receives other income that is paid directly to him/her (example would be wages from a job).

If **YES:** $Amount_____Source_____Circle one: Daily Weekly Monthly

SECTION III-MEDICALLY INDIGENT

Are your Out-of-Pocket Medical Expenses more than 10% of your Gross Income for the last 12 months?_____yes_____no

SECTION IV FINANCIAL ASSETS

Checking Account: $_____Savings Account: $_____Other: $_____

I certify the above information to be an accurate and complete statement of my financial status and give authorization for Clarity CGC to verify any information reported. I acknowledge that Clarity CGC has the right to request additional information in accordance with the Clarity CGC Financial Assistance Policy which can be obtained by contacting the Patient Financial Services office at 210-593-2240 or on our website at www.claritycgc.org. If the information requested by Clarity CGC is not provided, I understand that my application can become void and may not be considered for financial assistance.

_____ _____

Parent/Legal Guardian Signature Date

Financial Responsibility (to be completed by Patient Financial Services Staff)

Total Income:_____Number of Dependents:____Charity % Discount (see Sliding Fee Schedule):_____