FINANCIAL INFORMATION FORM

Name____________________________________ Date of Birth________________FP____________

PLEASE COMPLETE ONLY ONE OF THE FOLLOWING BOXES AND SIGN BELOW.

☐ I do NOT wish to apply for reduced fees at the time. I will pay 100% with cash, check, debit card or money order.

Your Medicaid/Medicare or insurance card and picture I.D. MUST be presented at each visit.

☐ I have an Ohio Medicaid Card Billing Number_______________________

☐ I belong to a Medicaid HMO Billing Number_______________________

- ☐ Paramount
- ☐ Buckeye
- ☐ Caresource

☐ I have Private Medical Insurance with______________________________Insurance Company

Subscriber ID Number_____________________

If insurance is not under your name, please provide the following information:

Name of policy holder___________________________ SS# of policy holder________________________

Date of birth of policy holder_______________ Your relationship to policy holder_____________________

Adress of policy holder____

Do you have an office visit copay? Yes No If yes, what is the amount?___________

Do you have a prescription copay? Yes No If yes, what is the amount? ___________

☐ I would like to apply for reduced fees. (Please record all that apply to your household).

☐ I am 17 years old or younger and need confidential services. Please calculate my fees based on my income only.

☐ I am 17 years old or younger and do not need confidential services. Please calculate my fees based on the household income.

☐ My hour wage is $________. I work ______hours per week.

☐ I live with my spouse/partner/parents who earn $________per hour. They work ____hours per week.

☐ I am in college or vocational school and receive the following funds for my living expenses:

Scholarships/loan$__________ Parents$_________ Other$__________per quarter/semester.

I attend______number of quarters/semesters a year

☐ I have the following additional income:

☐ Alimony$________ ☐ Unemployment$__________ ☐ Tips$_________ ☐ Other$_________

☐ Social Security$___________

The amount of income is $________________ per ☐ week ☐ month ☐ year

I certify the above information is accurate and complete.

Patient signature:__________________________________ Date:____

For Office Use Only – Required For All Patients Weekly Income:________________________________

Fee Category: ☐ Full ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ Medicaid/HMO ☐ Private Insurance ☐ BCCP ☐ Medicare

Verified By: (staff signature)________________________________ Date:_______________________________________

NO PATIENT WILL BE DENIED SERVICE DUE TO THE INABILITY TO PAY