



Patient Label

Insurance Information

Name of Insurance: Medicaid CHIP Medicare No insurance Other _____ ID# _____

Financial Information and Fees

LBU Community Clinic offers discounts for customers who are eligible. If you wish to be considered for a Sliding Fee Discount, we will need to collect household income to determine your eligibility. Proof of income may include check stubs and W2 Forms.

- YES, I wish to be considered for a Sliding Fee Discount.
- NO, I do not want to be considered for a Sliding Fee Discount.

Signatures

Patient Rights: I understand my rights and responsibilities as described in:

- Patients’ Rights and Responsibilities
- Notice of Privacy Practices

Consent for Electronic Sharing and Health Information Exchange (HIE): I give permission for LBU to share and get my health information using technology for my care, billing, and other health services.

I certify that the above information is true and correct. I understand that I am responsible for payment of medical and dental services not covered by insurance.

Patient/Parent/Legal Guardian

Date

Business Office Staff

Date

<i>For office use only</i>		<i>Financial Information</i>
Family Names	Date of Birth	<u>Income frequency (circle all that apply):</u> Paid weekly x 52 Paid every 2 weeks x 26 Paid twice monthly x 24 Paid monthly x 12 <u>Documentation</u> Check stubs Annual Tax Return Attestation
Total Gross Annual Income for Household \$		
Total in household including dependents		
LBU Fee Category (A, B, C, D, E):		