COUNTRY DOCTOR
community health centers

After-Hours Clinic | Carolyn Downs Family Medical Center | Country Doctor Community Clinic

PATIENT FINANCIAL AGREEMENT

Our mission is to improve the health of our community by providing high quality, caring, culturally appropriote health care that addresses the needs of people regardless of their ability to pay.

To fulfill this mission we must partner with our patients in sharing the cost of providing care. If you have insurance (Medicare, Medicaid, Private Insurance) please provide that information to the front desk staff. If you do not have insurance we have a sliding scale discount.

Patients may qualify for a discount if they provide the information required below. A more complete description of this program and process is included in the Patient Handbook.

❑ I choose not to provide income information and understand that I will be responsible for full payment of services.

IF YOU CHOOSE TO APPLY FOR THE SLIDING SCALE DISCOUNT, PLEASE PROVIDE ONE OF THE FOLLOWING:

❑ A copy of the last two month's pay, unemployment or benefit check stubs for every working or unemployed member that contributes to your household income; or, if you are not paid by check, a letter from your employer with your rate of pay, your hours worked per week and your gross monthly income.

OR

❑ If self employed, a copy of your last quarterly state business tax return.

OR

❑ Provide self declaration of how your basic living needs have been met for last two months. (Please attach a brief explanation as to how these needs have been met). If you are a full-time student, please provide copy of student registration.

PLEASE PROVIDE THIS INFORMATION WITHIN 30 DAYS OF TODAY'S VISIT TO QUALIFY FOR YOUR DISCOUNT. THANK YOU!

How many people in your household are supported by your income, including yourself:	

If you want to fill out this form for others in your household please complete the reverse side.

I understand the above information and agree to provide the requested information* to receive a discount. I understand that if I do not provide the information within 30 days, I will be billed at full fee.

PRINT PATIENT'S NAME	**PATIENT'S SIGNATURE**	**TODAY'S DATE**

* This information needs to be updated at least annually or when it changes.

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PLEASE PROVIDE INCOME INFORMATION FOR DISCOUNT		
Annual Income: $	**# in Household:**	
OTHER HOUSEHOLD MEMBERS ARE:		
NAME	**BIRTHDATE**	**RELATIONSHIP TO YOU**

RETURN COMPLETED FORM AND INCOME INFORMATION TO:

COUNTRY DOCTOR COMMUNITY CLINIC
500 19th Avenue East, Seattle, WA 98112
(206) 299-1600 (206) 299-1608 Fax

FOR OFFICE USE ONLY			
Flat Fee		MR#	
Initials:		Date	