

LITTLE RIVERS HEALTH CARE offers a sliding fee scale for patients without insurance in our service area. This service is determined by income and family size and will help with **medical and pharmacy** costs.

Yes I would like to sign up for Sliding Fee Scale

I am already on Sliding Fee Scale

Acknowledgement

I have received a copy of Little Rivers 2011 Payment Policy and understand that I am responsible for any deductibles, co-payments or non-covered service. I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and/or terminated from the services at LITTLE RIVERS HEALTH CARE. Initial: _____

Certification

I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at **LITTLE RIVERS HEALTH CARE** and report of the failure to the federal government. Initial: _____

Permission to Disclose Confidential or Behavioral Health Information

Little Rivers may disclose my MEDICAL information and/or my BEHAVIORAL HEALTH information to:

My pharmacy (pharmacies of my choosing where I have filled prescriptions.)

Other people we can talk to about **your care** or **your appointment**?

Name Relationship Phone

Name Relationship Phone

Medical Information **may**____/**may not**____ be disclosed on my answering machine
Appointment reminders **may**____/**may not**____ be disclosed on my answering machine.

____ Check here if you **wish to include** information on HIV or other sexually transmitted viruses, drug or alcohol related results in your medical records released

Please list any items you wish to be **excluded** from your medical records released. Initial: _____

FOR OFFICE USE ONLY

Notes:

Notice of Privacy Practices made available

Signature of Patient or Guardian

Date: _____