A, B, C, D or E
Expires:

MCHC HEALTH CENTERS

Patient Financial Screening

☐ **Payment Plan** ☐ **Sliding Scale** **Account #** _____

☐ **Hillside** ☐ **Dora St.** ☐ **Lakeview** ☐ **Little Lake**

Patient Name:_____ Date of Birth:_____

Patient Social Security #:_____

Responsible Person:_____ Date of Birth:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD – SPOUSE AND CHILDREN UNDER 18 – FOR WHOM YOU HAVE FINANCIAL RESPONSIBILITY

Name	**Date of Birth**
1.	
2.	
3.	
4.	
5.	

I/We do declare my/our monthly gross household income is: **$**_____

Payment Plan

Total $_____ Down payment $_____

Monthly payment $_____ for_____ months

By signing below, I agree that I am financially responsible for treatment I receive. I declare under penalty of perjury that the answers and documents I have provided are correct to the best of my knowledge. I understand that payment is required at the time of service and, if payments are not made in a timely manner, then the unpaid balance may be turned over to a collection agency.

Sliding-scale patients needing diagnostic services: *I authorize MCHC to release this information to another health care provider in order to qualify for their charity care program for diagnostic tests ordered by MCHC providers.*

_____ _____ _____

Patient's Signature *Date* *Patient Financial Services Representative*

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STATEMENT OF AUTHORIZATION

I hereby authorize Patient Financial Services (PFS) Representative _____ _____, of Mendocino Community Health Clinic, Inc. (MCHC), to assist me in my application for Medi/Cal / CMSP / Covered CA. This includes assistance in making the intake appointment and completing forms (Including the MC 210 Medi-Cal Application) and gathering verifications needed to establish my eligibility for medical coverage. The county Department of Social Services is authorized to share other confidential information regarding my eligibility for Medi-Cal with this designated Representative, except the following:

_____

_____

(To be completed by client if there are restrictions on information to be shared.)

I understand that information given to the clinic will not be shared with anyone else without my written consent.

_____ _____

Signature *Date*