RCMS COMMUNITY HEALTHCARE

A, B, C, or D
Exp.

☐RCMS – Gualala ☐RCMS – Point Arena ☐Point Arena Dental Clinic

Redwood Coast Medical Services - Patient Financial Screening

Patients are required to pay their sliding-scale fees at the time of service. No Patient will be denied services.

Patient Name: _____ Date of Birth: _____

Social Security #: _____

Responsible Person: _____ Date of Birth: _____

Mailing Address: _____

Physical Address: _____

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	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

I/We do declare my/our monthly gross household income is: $ _____ # in Household_____

You are requested to provide proof of income within your initial 30-day eligibility period. Initial here:_____

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

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

_____ _____ _____ _____

Patient or Guardian's Signature *Date* *RCMS Staff Signature* *Date*

RCMS Staff Only

Sliding Scale Account # _____ _____ _____

Date of discount authorization *Expiration date of authorization*

☐ **Patient or Family Member has emergency Medi-Cal Or High Share of Cost.**