DEKALB COUNTY
Board of Health

Financial Information

Patient's Name _____ Birth Date _____ Age _____

Most services offered by the DeKalb County Board of Health are provided at a reduced cost. The cost of some services can be further reduced by providing the necessary financial information. Please ask the clerk if the service you desire required financial information to receive an additional reduction from the basic fee.

Please complete one of the following Sections (A or B):

Section A

I do not wish to provide financial information to find out if I am eligible for a reduction in the basic fee. I will pay the full basic fee for services.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Section B

I understand that the financial information I supplied will be used to find out if I am eligible for a reduction based on the fee for the service I have requested. I certify that the information listed below is true to the best of my knowledge.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Name of family members living in your household. Please include yourself	Relationship	Date of Birth	Source of Income	Salary Before Taxes	
				Weekly	Monthly

Sign and date if information is still correct.

_____ _____ _____ _____
Signature of Patient, Parent or Legal Guardian Date Signature of Patient, Parent or Legal Guardian Date

_____ _____ _____ _____
Signature of Patient, Parent or Legal Guardian Date Signature of Patient, Parent or Legal Guardian Date

_____
Family Reg. Number

During the initial visit the patient, parent or legal guardian must complete the registration and consent form. Financial screening must be done on every patient visit if the cost of the service is based on sliding fee scale.

For additional visits during the first year, the patient may verify accuracy of number of family members and amount of income by signing and dating the form at the bottom. Financial information must be updated at one-year intervals and each time the family and/or income changes.