



RiverStone Health Clinic
Patient Income Attestation Form

Patient Name: \_\_\_\_\_ Account Number#: \_\_\_\_\_

Patient's present living arrangement: \_\_\_\_\_

Multiple horizontal lines for text entry.

Gross Monthly Support Provided \$ \_\_\_\_\_

Annual draws taken from business Tax Year \_\_\_\_\_ \$ \_\_\_\_\_

The information I have listed above is true and complete. I understand that if it is later found that I did not truly qualify for the sliding fee scale that I may be responsible for repayment of any discounts that I received but was not entitled to. I understand that a person who obtains or attempts to obtain, by fraudulent means, services to which they are not entitled, may be prosecuted under applicable state and federal laws. I agree to notify RiverStone Health of any changes in the above information as soon as possible, but within 10 days of my knowledge of the change.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Individual Providing Support Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SFS %: \_\_\_\_\_ Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_