RiverStone Health Clinic

Patient Income Attestation Form

Patient Name:_____Date of Birth: _____

Patient's present living arrangement:_____

_____

_____

_____

_____

_____

_____

_____

_____

Gross Monthly Support Provided $_____

Annual draws taken from business *(if applicable)* 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:_____