RiverStone Health Clinic
Sliding Fee Discount Program Enrollment

Patient Name ______________________________ Date of Birth ________________
(Please Print)

Does the patient have any form of health, medical or dental insurance, including Healthy Montana Kids, Medicaid or Medicare? ❑ YES ❑ NO

If yes, list the company and policy number ______________________________
Attach copy of current insurance card.

If no, offer Patient Care Manager Services to assist with enrollment.

Number of People in Family (*including self*) ______________________

Please list people in family or dependents:

	NAME	DATE OF BIRTH
1.	______________________________	____________________
2.	______________________________	____________________
3.	______________________________	____________________
4.	______________________________	____________________
5.	______________________________	____________________
6.	______________________________	____________________

Gross (before taxes) Monthly Income Amount $________________

Type of Documentation of Income: (Attach Copy)

- ❑ Copy of Pay Check Stub Date ____________________
- ❑ Copy of W-2 or Income Tax Form Date ____________________
- ❑ Child Support Date ____________________
- ❑ Other ______________________________ Date ____________________

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 report any changes in the above information.**

Patient Signature: ____________________________ Date: ____________________

Please fax, mail or bring to RiverStone Health Clinic, 123 South 27th Street, Billings, MT 59101.
Fax – (406) 247-3389