Patient's Name:_____
Date of Birth: _____

Insurance Information (Copy of Insurance Card is Required)

Heart of Florida Health Center will bill your insurance for services covered based on their insurance plan. Parents/Guardians must provide accurate and up-to-date insurance information to avoid delays. If insurance details are not updated or coverage changes, it may affect proper billing.

☐ PATIENT HAS NO INSURANCE

	Primary	Secondary	Dental	Vision
Insurance Company:				
Employer:				
Policy Holder's Name:				
Policy Number:				
Policy Holder's Date of Birth:	____/____/_____	____/____/_____	____/____/_____	____/____/_____
Relationship with Patient:	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian

Section 3: Income Attestation – Self-Declaration (Required for All patients)

1. **Household Size** (Number of people in the household, as defined by tax dependency rules)
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ (Specify: _____)

2. **Income Attestation** (Select the range that best represents your household's total income)
   ☐ $0 - $20,000
   ☐ $20,001 - $40,000
   ☐ $40,001 - $60,000
   ☐ $60,001 - $80,000
   ☐ $80,001 - $100,000
   ☐ $100,001 - $120,000
   ☐ $120,001 - $140,000
   ☐ Over $140,000

3. **Are you applying for the Sliding Fee Discount Program?**
   ☐ *Yes **(Complete Section #6)***
   ☐ *No: Please note:* By declining, I acknowledge that I am choosing to pay full fees for services received at Heart of Florida Health Centers Inc., including any fees not covered by my insurance. I agree to pay any balance in full.

Attestation Statement

*I certify that the information provided above is true to the best of my knowledge. I understand that this information may be subject to verification. I allow **Heart of Florida Health Center (HFHC)** to send bills and get payments from **Medicare, Medicaid, insurance, or other programs** that help pay for my medical care. I understand that if my insurance or program does not pay HFHC, I must pay for my care, including any copays, coinsurance, or deductibles. I agree to pay my bill on time.*

Print Name: _____ Relationship with Patient: Date:

Signature: _____ ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian ___/___/____

Patient's Name:_____
Date of Birth: _____

Sliding Fee Discount Application

(Complete this section only if applying for the Sliding Fee Discount Program.)

Proof of Income (Check all that apply.)	***Government-Issued Identification (Required for all applicants.)***
☐ *Wages and Federal Tax Statement (e.g., W-2)* ☐ *Recent Paystubs* ☐ *Determination or Benefits Verification Letter* ☐ *Self-Employment Ledger Documentation* ☐ *Employer Statement (Signed on company letterhead)* ☐ *Other: _____* ☐ ***No Proof of Income Provided (Complete Self-Declaration of No Income below)***	☐ *Driver's License* ☐ *Passport* ☐ *U.S. Immigration Form* ☐ *Other:* _____

Declaration of No Income

(Complete only if you selected "No Proof of Income Provided" above.)

1. **I confirm that I do not receive money from any of the following sources:**
   - *Wages from a job (including tips, bonuses, or commissions)*
   - *Money from my own business*
   - *Rent payments from property I own*
   - *Interest or dividends from savings or investments*
   - *Social Security, retirement, pension, or insurance payments*
   - *Unemployment or disability benefits*
   - *Government assistance (such as food stamps or cash aid)*
   - *Alimony, child support, or financial help from someone outside my household*
   - *Money from selling products (e.g., Avon, Mary Kay, etc.)*
   - *Other income*

2. **Certification of Financial Support**
   I confirm that I have no income right now and do not expect any changes soon. If my financial situation changes, I will inform Heart of Florida Health Centers Inc. My basic needs (housing, food, utilities) are covered by:

Name: _____ or **Agency (if applicable):** _____
Phone: _____ **Address:** _____

3. **Acknowledgment & Certification**
   I confirm that the information I provided is true and correct to the best of my knowledge. I understand that giving false, incomplete, or misleading information may result in losing assistance from **Heart of Florida Health Centers Inc.**

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/_____

Signature: _____