Girdwood Health Clinic

Statement of Financial Responsibility

Verification of Accuracy	
Initials	Please initial next to each statement below that you have read and understand
	I certify that the information in my Sliding Fee Discount Program application is true and accurate to the best of my knowledge and that submission of false information will automatically disqualify me from this program. I understand that I must notify the clinic as soon as possible and fill out a new Sliding Fee Program Application if my financial circumstances change.
	I understand that it is my responsibility to know the status, effective date, and ending date of my sliding fee and that I can call the clinic to retrieve this information. It is my responsibility to keep in contact with the clinic regarding all sliding fee scale matters, information and processes.
	I understand that I am responsible for paying the nominal fee(s) at time of service unless the urgent nature of the visit prevents payment in which case I will contact the clinic as soon as possible to arrange payment.
	I understand that I must submit proof of income within 10 business days of submitting my application and that the Slide Discount will not be applied until my application has been approved. Incomplete applications will be denied without notification from the Clinic. I understand that my application is not complete until signed by a Girdwood Health Clinic representative.

Please initial and date