Acknowledgement of
Patient Handbook & Sliding Fee Scale Application

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Patient Name: SSN:

PATIENT HANDBOOK:

I acknowledge I received a copy of the Triad Health Systems', Inc. Patient Handbook. I understand policies are subject to change at any time. I understand that I may request an updated copy of the handbook at the front desk of any of the Triad Health Systems', Inc. clinics in Carroll, Gallatin or Owen Counties.

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PATIENT SLIDING FEE SCALE:

I have been offered a copy of the Triad Health Systems', Inc. Sliding Fee Scale Application. If I wish to apply, I understand that it is my responsibility to complete the application and provide any documentation required (such as proof of income, etc.) and any prices quoted at the time of the visit, should be considered an estimate only. I understand that if I do not participate in the Sliding Fee Scale program at this time and/or my information changes that I may reapply at any time by requesting an application from any Triad Health Systems', Inc. clinics in Carroll, Gallatin or Owen Counties.

☐ **I choose not to participate in the Sliding Fee Scale at this time.**

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Your signature below indicates you have read and understand the acknowledgements above and acknowledge that you have been offered a copy of the Triad Health Systems, Inc. Patient Handbook and the Sliding Fee Scale Application.

_____ _____

Client/Representative Signature: Date:

_____ _____

Witness Signature: Date: