ILIULIUK FAMILY AND HEALTH SERVICES, INC.

PO Box 144
34 Lavelle Court
Unalaska, AK 99685

FINANCIAL INFORMATION/AGREEMENT

Name: _____ Date of Birth: _____

Because we receive Federal funds, we are required to ask:
What is your family size here in Unalaska/Dutch Harbor (include yourself)? _____
Annual household income: _____
Initial each section below and sign at the bottom, thank you!

_____ AUTHORIZE TREATMENT: I authorize treatment for myself or the person named above by the staff at Iliuliuk Family and Health Services, Inc.

_____ APPOINTMENT CANCELLATION: Patients are required to notify IFHS of a cancellation at least 24 hours prior to the scheduled appointment times. A fee will be charges to patients who will fail to keep two or more appointments in one year without proper notice of cancellation. This charge is the patients' responsibility and not covered by insurance or workers compensation. A separate fee will be assessed for each failed appointment. The initial fee will be $25 and will increase incrementally by $254 with each subsequent failure. If you are later than 10 minutes to your scheduled appointment, your visit will be considered cancelled; in which the above fees will apply.

_____ FINANCIAL AGREEMENT: I agree to pay all fees and charges shown by statements for myself or the above named person promptly upon presentation thereof, unless credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct unless protested in writing within thirty (30) days of billing date. In the event legal action become necessary to collect unpaid balance, I agree to pay reasonable attorney fees or the other costs as the court determines proper.

_____ BILLING ADDRESS: I am certifying that the address listed on my demographic page is the correct billing address to send my billing statements to. It is my responsibility to update this address as needed. I understand that my bill will be sent to collections automatically upon receipt of 'return to sender' mail.

_____ RECORD RELEASE: I authorize Iliuliuk Family and Health Services, Inc. to release my, or the person named above, medical records to myself or person named below, worker's compensation, insurance carrier, employer, or out for medical consultation.

1. _____
2. _____
3. _____

Please circle the appropriate choice Y or N OK to leave message on Voicemail or answering machine.

_____ RECEIPT OF NOTICE OF MEDICAL INFORMATION: I have received the Iliuliuk Family and Health Services, Inc. "Notice of Medical Information Use".

These authorizations are good for two years from the date signed and a copy of these agreements is as valid as the original.

Signature:_____ Date: _____

_____

Print the name and relationship to the person named above (if not signature of the person named above)