T.H.E CLINIC, INC.
3834 S. Western Avenue
Los Angeles, CA 90062

Income Verification and Assignment of Benefits

Household Monthly Income (Gross Income – before taxes): ______________________
Household Size: ____

Do you have any type of Medical Insurance?	☐ Yes	☐ No
Do you receive any government assistance, i.e. GR, AFDC?	☐ Yes	☐ No
Are you under a family planning program from Family P.A.C.T.?	☐ Yes	☐ No

Type of Verification**:**

☐ Work Check Stub
☐ Oral / Written Verification from employer
☐ Unemployment Compensation Award
☐ Social Security Check Stub
☐ W-2 or Income Tax Form
☐ Patient was informed to bring documents.

I certify that the above information is true and accurate to the best of my knowledge. I understand that this verification is made so that T.H.E. Clinic, Inc. can determine my eligibility for payment of medical procedures and/or laboratory services based on the established criteria in the clinic. If any information I have given proves to be untrue, I understand that T.H.E. Clinic, Inc. may reevaluate my financial status and if I have already received services, I am obligated to pay the cost rendered.

Authorization for Assignment for Benefits

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits directly to T.H.E. Clinic, Inc. for services rendered as described on the claim.

I acknowledge full responsibility for these charges and agree to pay in full for any and all additional costs including any portion not covered by my insurance coverage.

______________________________ ______________________
Patient's Signature or legal representative Date

Staff's Signature: ______________________________ Date: ______________________

NAME: ______________________________ **D.O.B.**: ________________ **ACCT. #:** ____________

Revise: 01/29/2010