Annual Patient Update

The following information is needed to assist the clinic in securing funds. Your cooperation is appreciated. Please circle the correct amount or check the box if income is above all amounts.

Number of Persons in Household	1	2	3	4	5	6
Household Income is Less Than	12,880	17,420	21,960	26,500	31,040	35,580
Household Income is Less Than	19,320	26,130	32,940	39,750	46,560	53,370
Household Income is Less Than	25,760	34,840	43,920	53,000	62,080	71,160
Income is Above all amounts	☐	☐	☐	☐	☐	☐

Have you ever been in the military? Yes No **Have you been seen at the VA?** Yes No
US citizenship: By Birth Permanent Resident/Alien Student Visa Other
Race: Black White Asian American Indian Pacific Islander Hawaiian Other
Ethnicity: Hispanic Non-Hispanic Choose not to disclose
Language Spoken: ________________________ **Do you need a translator?** Yes No
Are you: 1) a single parent? Yes No 2) **Homeless?** Yes No 3) **Resident of public housing**? Yes No
Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose
Sexual Orientation: Straight Lesbian/gay Bisexual Other Don't know Choose not to disclose

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Aviva Health, to render needed treatment to the above named patient.
2. I authorize Aviva Health to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to Aviva Health for services rendered.
4. I understand that I am responsible for all charges incurred through Aviva Health.

I request that payment under the medical Insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If it becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature of applicant:____**Date:**________________

Signature Parent/Guardian____________________________________**Date:**______________

Staff initials/Date____