Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-6823 – Dental

Payment Acknowledgment Form

(Please sign next to one of the following)

A. I, ________________________________, acknowledge that I have Medicaid or private insurance and **that I will provide a copy of my active insurance information** on the date of my visit. If, for any reason, my insurance company denies payment, I understand that I am liable for all charges incurred. If insurance pays a portion of the charges, I understand the remainder is my responsibility.

B. I, ________________________________, **acknowledge that I have been approved for the sliding scale fee**. I know my fee per visit and understand that this flat fee is my responsibility to pay along with any additional fees for labs, and immunizations. I also understand that my sliding fee approval is only active for one year, after which, I need to bring in proof and apply again.

C. I, ________________________________, **acknowledge that my sliding fee has expired**. I promise to bring proof of income as described in the Sliding Fee Guidelines to Maple Street Clinic (109 E. Maple Street, Gillespie) or Morgan Street Clinic (1115 Morgan Street, Carlinville) within seven (7) business days. I understand that I do not comply with this agreement, I am liable for all charges incurred on each visit from here forward (until sliding fee paperwork and proof are provided).

D. I, ________________________________, **acknowledge that I do not have an active sliding fee on my account, nor do I want to apply**. I understand that by refusing to sign the Sliding Fee packet and provide proof of income, which I am agreeing to submit proof of insurance, or to pay “out of pocket.” All charges incurred from this date forward are my responsibility.

Thank you for allowing us to serve your medical, dental, and behavioral health needs.

Patient Name: ________________________________ Patient DOB: ________________

Account Guarantor Signature: ________________________ Date: ________________

Payment Acknowledgement is valid for one year from date of signature unless voided by patient or MCPHD.