FCPC

Personal Attestation of Income

Name		**Social Security**	
Address		**City and State**	
Employer		**Home Phone**	
Address		**City and State**	

TOTAL NUMBER OF PEOPLE IN PATIENT'S HOUSEHOLD: _______

HOUSEHOLD MEMBER	INCOME	CIRCLE ONE
Patient	$	Hourly / Weekly / Monthly / Yearly
Spouse	$	Hourly / Weekly / Monthly / Yearly
Patient's Father	$	Hourly / Weekly / Monthly / Yearly
Patient's Mother	$	Hourly / Weekly / Monthly / Yearly
Other	$	Hourly / Weekly / Monthly / Yearly
Other	$	Hourly / Weekly / Monthly / Yearly

ATTESTATION STATEMENT

The discounted fee program applies to First Choice Primary Care charges only and does not apply to other services patient may receive. I have received a copy of the First Choice Primary Care Discounted Fee Program and I understand that I am responsible for all applicable Co-payments as determined by First Choice Primary Care.

I certify that the household size and income information provided above is correct. I understand that providing knowingly false information will result in my dismissal from care from this facility.

5/20/2014

______________________________________ ____________

Patient or Guarantor Signature **Date**

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