



FINANCIAL INTAKE FORM

1. INCOME INFORMATION

Type of Income:

- Wages, salary, tips \$ _____
- Pension \$ _____
- VA Benefits \$ _____
- Unemployment (label) \$ _____
- Social Security Disability (SSDI) \$ _____
- Supplemental (SSI) \$ _____
- Welfare /GAU \$ _____
- Other: Please specify \$ _____

How often: Monthly Other _____
(Please specify)

Number of persons supported by this income: _____

PLEASE PROVIDE COPIES OF INCOME TO KANG WEN FRONT STAFF

FOR OFFICE PERSONNEL:

Type of Income Verification:

<input type="checkbox"/> W2/1040	<input type="checkbox"/> DHHS/Soc Security Letter	<input type="checkbox"/> Recent Paystub
<input type="checkbox"/> Bank statements (most recent 3 months)		<input type="checkbox"/> Date Completed

2. KANG WEN BILLING POLICY

(please initial each item)

_____ *I understand that I am financially responsible for all charges and agree to pay for services rendered at time of visit.*

_____ *I also understand if I make an appointment and do not show up, that because this missed appointment deprives another client of the opportunity to receive treatment and my **failure to provide 24-hours advanced notice of my cancellation will result in a fee of 50% of my treatment fee.***

_____ *If I arrive late to my appointment, Kang Wen will do the best of their ability to treat me within my designated appointment time. However, I understand that my*

treatment may be shortened or cancelled.

_____ *I also understand that if I miss more than 3 appointments without 24 hours notice, I will be restricted to drop-in treatments only.*

_____ *For all returned checks written by me, Kang Wen will require payment of all charges incurred by their banking institution.*

3. KANG WEN CHARITY PROGRAM

I would like to contribute \$_____ to be added to my copay to help other clients at Kang Wen who may need assistance with their treatment fees. I understand that my contribution is tax deductible and I will receive an annual statement that details my contribution.

Patient Signature

Guardian/Patient Representative Signature

Patient Name (PRINT)

Guardian/Patient Rep Name (PRINT)

Date

Date