



PEDIATRIC PATIENT REGISTRATION FORM

Today's Date: _____

Form Type: New Patient Annual Update

PATIENT INFORMATION				
Legal Last Name:		Legal First Name:		Legal Middle Name:
Preferred First Name:				
Previous Full Name (if applicable):		Birth Date: / /	Age:	Social Security #:
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Intersex <input type="checkbox"/> Not recorded on birth certificate				
<i>For Patient 12 Years or Older . . .</i>	Patient Cell Phone: <input type="checkbox"/> N/A		Patient E-mail Address: <input type="checkbox"/> N/A	
Parent/Legal Guardian Name:		Cell Phone:	E-mail Address:	
Mailing Address:			City:	State:
Zip Code:				
Best way to contact for results, follow up, or scheduling? (check all that apply)				
<input type="checkbox"/> Parent/Guardian Cell Phone <input type="checkbox"/> Parent/Guardian E-mail <input type="checkbox"/> Patient Cell Phone <input type="checkbox"/> Patient E-mail				
Race:			Ethnicity:	
<input type="checkbox"/> Alaskan Native <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Chinese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unknown <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Refuse to disclose <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific Islander			<input type="checkbox"/> Mexican, Mexican American, or Chicano/a <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Multiple Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Non-Hispanic or Latino/a <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse to disclose	
Sexual Orientation:		Gender Identity:		Preferred Pronouns:
<input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Omnisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Don't know <input type="checkbox"/> Something Else to disclose		<input type="checkbox"/> Female <input type="checkbox"/> Questioning <input type="checkbox"/> Male <input type="checkbox"/> Two Spirit <input type="checkbox"/> Transgender Female <input type="checkbox"/> Refuse to disclose <input type="checkbox"/> Transgender Male <input type="checkbox"/> Refuse to disclose <input type="checkbox"/> Non-Binary / Genderqueer <input type="checkbox"/> Other: _____		<input type="checkbox"/> she / her / hers <input type="checkbox"/> ey / em / eirs <input type="checkbox"/> he / him / his <input type="checkbox"/> ve / vir / vis <input type="checkbox"/> they / them / theirs <input type="checkbox"/> xe / xem / xyrs <input type="checkbox"/> patient's name <input type="checkbox"/> Refuse to disclose <input type="checkbox"/> ze / hir / hirs <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
EMPLOYMENT STATUS OF PARENT / GUARDIAN				
Employment Status of Parent/Guardian:			Veteran/Military Status of Parent/Guardian:	
<input type="checkbox"/> Full time <input type="checkbox"/> Self-employed <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Part time <input type="checkbox"/> Not employed <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> On Active Military <input type="checkbox"/> Retired due to disability duty			<input type="checkbox"/> No previous experience <input type="checkbox"/> Veteran <input type="checkbox"/> Active Duty <input type="checkbox"/> Separated / Combat <input type="checkbox"/> Inactive Duty Veteran <input type="checkbox"/> Reservist	
Is the patient a dependent of a current or former employee of our company? <input type="checkbox"/> Yes <input type="checkbox"/> No				
INSURANCE				
If the patient is uninsured or has Medicaid, please complete <i>Primary Insurance Type</i> and skip the remaining questions. If the patient has Medicare or Private insurance, fill in the details below.				
Primary Insurance Type: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private / Other				
Insurance Company Name:			Insurance ID #:	
Subscriber Name:			Subscriber Date of Birth: / /	
Secondary Insurance Company Name:			Secondary Insurance ID #:	



PEDIATRIC PATIENT REGISTRATION FORM

HOUSEHOLD INCOME

Collecting this information allows us to offer you discounted services. If you do not know your monthly income, ask us for help.

Number of Household Members (include yourself):	Monthly Household Income (estimated):
	\$

FINANCIALLY RESPONSIBLE PARTY

Individual listed on the patient's account for billing purposes.

Parent/Legal Guardian Responsible for Bill:	Birth Date: / /	Social Security #:	
Mailing Address:	City:	State:	Zip Code:
Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work			

LANGUAGE

What language do you <i>speak</i> at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No Preference
What language do you <i>write</i> at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	

ADDITIONAL INFORMATION

We are a community health center with a mission to serve all regardless of ability to pay or lack of insurance, including individuals and families experiencing homelessness or those employed in agricultural activities.

Homelessness Status of Patient:

<input type="checkbox"/> Not Homeless	<input type="checkbox"/> Permanent Supportive Housing	<input type="checkbox"/> Veteran at Risk for Homeless
<input type="checkbox"/> Child at Risk for Homeless	<input type="checkbox"/> Living with Others	<input type="checkbox"/> Single Occupancy Hotel
<input type="checkbox"/> At Risk for Homeless	<input type="checkbox"/> Homeless, Unknown Shelter	<input type="checkbox"/> Street, Camp, Bridge
<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Living in Shelter	<input type="checkbox"/> Currently Not Homeless, was in the last 12 Months

Agricultural Workers: In the last 2 years, have you or another member of your household worked in any type of agriculture (farm work) that may include: soil prepping, planting, picking, cleaning, sorting, packing, transporting, or work with livestock, etc.?
 Yes No (if no, do not answer the two questions below)

Migrant – In the last 2 years, you or a member of your household has lived away from home in order to work in any type of agriculture (farm work). OR in the last 2 years, have you or a member of your household stopped migrating to work in agriculture (farm work) because of a disability or age (too old to work)?

Seasonal – In the last 2 years, you or a member of your household do farm work that only happens at certain times throughout the year.

SIGNATURE & AUTHORIZATION

I authorize Neighborhood Health Center (NHC) to furnish information regarding the patient's medical history, diagnosis, and treatment to their insurance company regarding claims for benefits. If said insurer fails to meet this obligation or if the patient is non-insured, I agree to be responsible for any fees related to treatment of the above-named patient. I acknowledge I have been provided NHC's Notice of Privacy Practices which explains how information may be used and/or shared as required/permitted by law. I acknowledge that I have been provided with, and will adhere to, NHC's Patient Rights and Responsibilities as the primary caretaker of the patient. On behalf of the named patient, I hereby consent to treatment by NHC professional staff and/or students under direct supervision of licensed NHC clinicians, either at a NHC clinic or via telehealth (i.e., audio and/or video encounter). I understand services will be delivered to the patient in their preferred language of understanding and that this consent to treatment is effective 12 months beyond the date of signature. On behalf of the patient, I hereby give my consent for treatment by NHC and understand that I may cancel this consent at any time, in writing.

_____	_____
Printed Name of Patient or Parent / Guardian	Date
_____	_____
Signature of Patient or Parent / Guardian	Date



COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

How May We Contact You?

1. How would you like us to notify you of upcoming appointments?
Note, these are automated messages.
 Phone Call Text Message Do not contact me
2. If an earlier appointment becomes available, how would you like to be notified?
 Text Message Phone Call E-mail Do not contact me
3. May we e-mail you regarding payment for services?
For example, statement or estimate is available, balance due, due date. This can also be viewed in MyChart.
 Yes No
4. How would you like to be notified when your payment is processed?
 Mail (USPS) E-mail MyChart Do not contact me
5. May we send letters to your address about clinic-specific changes that impact your care?
Examples: Your provider has left the organization, the clinic is relocating, or your provider recommends a visit.
 Yes No
6. Would you like to receive Neighborhood Health Center's (NHC) quarterly e-mail newsletter?
 Yes No
7. May we send you a survey regarding your experience at NHC?
 Yes No
8. Have you signed up for MyChart, or would you be willing to sign up for MyChart?
The MyChart electronic patient portal allows you to view lab results, request prescription refills, and communicate directly with your care team.
 Yes: Continue to questions 9-13 No: Please skip to Page 2: Authorization(s)

Complete questions 9-13 ONLY if you answered YES to question 8

9. How would you like to be notified of changes made to your MyChart account?
For example, account locked, new device connected, password changed, contact information changed, etc.
 Text Message E-mail Do not contact me
10. May we e-mail you about tasks you need to complete in your MyChart account?
 Yes No
11. How would you like to be notified if you have documents to sign or document updates to review?
 Text Message E-mail MyChart Do not contact me
12. Should we notify you by e-mail that test results, such as labs, are available?
We will not provide results via e-mail, only a notification that lab results are available to view in MyChart.
 Yes No
13. How would you like to be notified when your provider or care team sends you a MyChart message, a care reminder, or reminder for upcoming virtual visits?
 Text Message E-mail Do not contact me



COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Authorizations: Who May We Speak To Regarding Your Healthcare?		
Name:	Relationship:	
Phone Number:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Add as Your Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorized to Sign on Behalf of Parent/Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
What information are we authorized to disclose to this person? Please check all that apply: <input type="checkbox"/> All information <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Medical Instructions / Advice <input type="checkbox"/> Medical <input type="checkbox"/> Reproductive Health <input type="checkbox"/> Appointment Scheduling <input type="checkbox"/> Dental <input type="checkbox"/> Medication Information <input type="checkbox"/> Other: _____		

Name:	Relationship:	
Phone Number:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Add as Your Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorized to Sign on Behalf of Parent/Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
What information are we authorized to disclose to this person? Please check all that apply: <input type="checkbox"/> All information <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Medical Instructions / Advice <input type="checkbox"/> Medical <input type="checkbox"/> Reproductive Health <input type="checkbox"/> Appointment Scheduling <input type="checkbox"/> Dental <input type="checkbox"/> Medication Information <input type="checkbox"/> Other: _____		

Legal Representative, Guardian, Power of Attorney, Etc. (If any)	
Name:	
Relationship:	Phone Number:

Signature & Authorization	
I understand I may change or revoke this authorization in writing, at any time. It will remain in effect until one (1) year from the date below. I understand I am responsible to notify my clinic if I have changes.	
Signature (Patient or Legal Guardian):	Date:
Print Name (Patient or Legal Guardian):	Relationship (if not patient):



PEDIATRIC NEW PATIENT HEALTH HISTORY (0-2 YRS)

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your baby and support for you.

Baby's Name: _____ DOB: _____

Name of person filling out form: _____

I am this baby's: Mother Father Grandparent Foster Parent Other: _____

Is your baby taking any medications, vitamins, or supplements regularly? No Yes If yes, what: _____

Does your baby have any allergies (medicine, foods)? No Yes If yes, to what: _____

Has your baby been vaccinated? No Yes Where did your baby receive prior vaccinations? _____

MOTHER'S PREGNANCY & BABY'S BIRTH HISTORY

Did mother receive prenatal care? No Yes How many months pregnant when prenatal care began? _____

Did mother use any of the following during pregnancy (check if taken during any part of pregnancy)?

- Prescribed medications: _____ Tobacco Marijuana
- Over the counter medications: _____ Alcohol Other drugs

Were there any problems during pregnancy / labor / delivery? No Yes If yes, explain: _____

Was baby born prematurely? No Yes Number of weeks pregnant at delivery? _____

Born at: Hospital-Name of hospital: _____ Home Delivery: Vaginal Cesarean

Place of Birth: City _____ State _____ Country _____

Birth weight: _____ pounds _____ ounces Birth length: _____ inches

BABY'S HEALTH PROBLEMS (Check box if your baby has had any of these)

- Anemia Constipation Hearing Problem Seizures / Epilepsy
- Asthma Developmental delay Heart Problem/ Murmur Sickle Cell Disease
- Birth defect: _____ Eczema Liver Problem Toothache / Decay
- Bleeding problem Eye / Vision Problem Kidney / Bladder Problem Tuberculosis
- Bone/joint/muscle problem Frequent ear infections Pneumonia Urinary tract infection (UTI)
- Chicken pox Other: _____

Has your child been hospitalized or had surgery? No Yes When / why: _____

FAMILY MEDICAL HISTORY (Check if your child's biological siblings, parents, or grandparents have had any of the following):

	Relationship to child		Relationship to child
<input type="checkbox"/> Alcohol/drug problem	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Autism	_____	<input type="checkbox"/> Intellectual disability	_____
<input type="checkbox"/> Birth defect	_____	<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Bleeding disorder	_____	<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Seasonal allergies	_____
<input type="checkbox"/> Childhood hearing loss	_____	<input type="checkbox"/> SIDS	_____
<input type="checkbox"/> Developmental delay	_____	<input type="checkbox"/> Stroke before age 50	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Other:	_____
<input type="checkbox"/> Epilepsy/ Seizures	_____	_____	_____
<input type="checkbox"/> Heart problem before age 55	_____	_____	_____

Signature: _____

Date: _____



SLIDING FEE DISCOUNT PROGRAM

APPLICATION

INSTRUCTIONS

1. In order to receive discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero (\$0) for their monthly income.

PERSONAL INFORMATION

Full Name	
Address	
Phone Number	
Today's Date	

FAMILY MEMBERS

- Family is defined as a group of two or more people living together who are financially supporting one another.
- Report \$0 under 'Monthly Income' for any family members who do not support you financially.

Full Name	Date of Birth	Relationship	Monthly Income (before taxes)
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$

IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED

How long have you been without a taxable source of income?	<input type="checkbox"/> > 6 months <input type="checkbox"/> 6 months-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 years
Why are you unable to provide proof of income?	

ATTESTATIONS

Please read and initial next to each attestation

	I attest that I have read the <i>Sliding Fee Discount Program Information</i> sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

SIGNATURE

I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.

Applicant Signature	Date



-----DO NOT WRITE BELOW THIS LINE-----

OFFICE USE ONLY

Applicant/s Information		Proof of Income Status: A or B	
Patient/s MRN		Monthly Family Income (verified by proof)	\$
Monthly Family Income (from table on pg.1)	\$	Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Family Size (from table on pg.1)		Date Verified	
Proof of Income Status at Time of Application	<input type="checkbox"/> A. Yes, proof attached <input type="checkbox"/> B. Pending, 30-day grace period <input type="checkbox"/> C. No, applicant has listed zero or cash source of income, pending approval by COO or designee	Reviewed By	
		Proof of Income Status: C	
Date		Decision	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Reviewed By		Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
		Date of Review	
		Signature of COO or Designee	

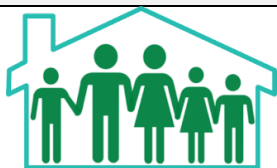


SLIDING FEE DISCOUNT PROGRAM INFORMATION

WHY SHOULD I SIGN UP FOR THE PROGRAM?

Neighborhood Health Center (NHC) offers discounted services to patients living at or below 200% of the most current Federal Poverty Guidelines (FPG). Eligibility to participate in the program is based only on the patient's household income and family size, as it relates to FPGs. All patients are encouraged to apply, including patients with insurance. Discounts apply to all NHC services provided directly at NHC clinics and those offered in referral. Discounts vary depending on the patient's assigned discount pay class (see Discount Classes A-D in the Monthly Income table below) and the service being used by the patient at the time of appointment (i.e. medical, dental, or behavioral health). Please take a moment to review this information sheet prior to filling out your application. If you have questions, please ask an NHC staff member for assistance.

WHO SHOULD I INCLUDE IN MY FAMILY SIZE?



NHC defines a family as a group of two or more people living together who are financially supporting one another.

Do NOT include:

- Family members who do not live with you
- Family members who are financially independent

Still not sure who to include? Ask us!

WHAT IS ACCEPTABLE PROOF OF INCOME?

For each member contributing income to the family, attach at least one of the following documents to your application:

- ✓ Two (2) weeks of most recent pay stubs
- ✓ Check stubs from Unemployment Insurance
- ✓ Previous year W-2
- ✓ Previous year completed tax return
- ✓ Government-issued documentation for other non-wage income such as Social Security, Worker's Comp, Cash Assistance, Child Support, Alimony, Veteran's Benefits, Retirement, or Pension
- ✓ Previous three (3) months of bank statements
- ✓ Letter from employer
- ✓ If self-employed: prior year tax return or most recent three (3) months of bank statements

WHAT DISCOUNT WILL I RECEIVE?

Below is a table displaying the 2024 Federal Poverty Guidelines (FPG). Only patients reporting a family income at or below 200% of FPG will qualify. Columns A through D are eligible for discounted services. Column E (above 200% FPG) must pay in full for charges and will not receive a discount. If you fall within Column E, you are not eligible to participate in the program.

MONTHLY INCOME											
Discount Class	A		B		C		D		E		
FPG	0-100%		>100-133%		>133-166%		>166-200%		>200%		
1	\$0	\$1,255	\$1,256	\$1,669	\$1,670	\$2,083	\$2,084	\$2,510	\$2,511	& Up	
2	\$0	\$1,703	\$1,704	\$2,265	\$2,266	\$2,828	\$2,829	\$3,407	\$3,408	& Up	
3	\$0	\$2,152	\$2,153	\$2,862	\$2,863	\$3,572	\$3,573	\$4,303	\$4,304	& Up	
4	\$0	\$2,600	\$2,601	\$3,458	\$3,459	\$4,316	\$4,317	\$5,200	\$5,201	& Up	
5	\$0	\$3,048	\$3,049	\$4,054	\$4,055	\$5,060	\$5,061	\$6,097	\$6,098	& Up	
6	\$0	\$3,497	\$3,498	\$4,651	\$4,652	\$5,804	\$5,805	\$6,993	\$6,994	& Up	
7	\$0	\$3,945	\$3,946	\$5,247	\$5,248	\$6,549	\$6,550	\$7,890	\$7,891	& Up	
8	\$0	\$4,393	\$4,394	\$5,843	\$5,844	\$7,293	\$7,294	\$8,787	\$8,788	& Up	
9	\$0	\$4,842	\$4,843	\$6,439	\$6,440	\$8,037	\$8,038	\$9,683	\$9,684	& Up	
10	\$0	\$5,290	\$5,291	\$7,036	\$7,037	\$8,781	\$8,782	\$10,580	\$10,581	& Up	

*FPG: Federal Poverty Guidelines, published by HHS, effective 01/17/2024
For families/households with more than 10 persons, add \$448 for each additional person*

EXAMPLE 1

Susan is a single mother of two young children, Susan also cares for her mother, who lives with her and her children. Susan's family size is 4. Susan is the only person in her family earning income. Susan earns \$2,700 per month in income. Susan belongs to Discount Class B.

EXAMPLE 2

Jose is married to his wife Miranda. They have three young children who live with them. Jose earns \$2,800 per month at his job. Jose's wife earns \$2,700 per month. Together, the couple earns \$5,500 per month. Jose's family size is 5. Jose belongs to Discount Class D.

WHAT AM I RESPONSIBLE TO PAY?

Once you figure out what Discount Class you belong to (A-D), discounts vary depending on the service you are using at the time of your service. Services are broken into groups and include medical, reproductive health, dental, behavioral health, and pharmacy.

Discounts apply to clinical services. Note that dental and pharmacy supplies and equipment have separate discounts because they are not clinical services.

	A	B	C	D	E
Medical & Clinical Pharmacy Services	\$25	\$35	\$40	\$45	100% of Full Charges
Reproductive Health Services	\$0	ASK FOR A COPY OF THE REPRODUCTIVE HEALTH SERVICES PROGRAM DISCOUNT SCHEDULE			
Dental Services*	\$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Dental Supplies & Equipment*	50% of Full Charges	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health Services	\$5	\$10	\$15	\$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	\$5 Dispensing Fee + Discounted Medication Cost	\$8 Dispensing Fee + Discounted Medication Cost	\$10 Dispensing Fee + Discounted Medication Cost	\$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

*\$25 payment expected at the time of service.

**Ask your Pharmacist for a quote on your medications. Call 503-941-3160 for more information.

EXAMPLE 1

I belong to Discount Class B. I came in today for a medical visit with my Doctor. I am responsible to pay \$35 for my visit. The remainder of my charges will be adjusted by NHC so that \$35 is my only responsibility.

EXAMPLE 2

I belong to Discount Class C. I came in today for a dental exam and cleaning. The total of these charges was \$300. I am responsible to pay 60% of these charges. The remainder of my charges will be adjusted by NHC so that \$180 is my only responsibility (\$180 = 60% of \$300 charges).

EXAMPLE 3

I belong to Discount Class D. I came in today for an appointment to discuss my diabetes with a behavioral health consultant. I am responsible to pay \$20 for my visit. The remainder of my charges will be adjusted by NHC so that \$5 is my only responsibility.

EXAMPLE 4

I belong to Discount Class A. I would like to speak with my Doctor about different kinds of birth control. This service is free of charge so I owe nothing for this visit.

REPRODUCTIVE HEALTH SERVICES

The discount schedule above does not apply to reproductive health services offered at NHC. The Oregon Health Authority (OHA) has developed a separate schedule of discounts for these services. If your family income is at or below 250% of Federal Poverty Guidelines (FPG), you qualify for discounted reproductive health services. If your family income is at or below 100% of FPG, these services are free to use. **Refer to the REPRODUCTIVE HEALTH SERVICES PROGRAM DISCOUNT SCHEDULE for discounts.**



I NEED MORE INFORMATION

Not sure who to include in your family size? Not sure what to bring to prove your income? Not sure what discount class you will qualify for? Not sure what you will be charged for a specific service?

Ask the front desk staff at your NHC clinic to answer any additional questions you have.

NEIGHBORHOOD HEALTH CENTER 2024 SLIDING FEE DISCOUNT SCHEDULE

What Discount Do I Qualify For?

ANNUAL INCOME											
Category	A		B		C		D		E		
FPG	0 - 100%		>100 - 133%		>133 - 166%		>166 - 200%		>200%		
Family Size	1	\$ -	\$ 15,060	\$ 15,061	\$ 20,030	\$ 20,031	\$ 25,000	\$ 25,001	\$ 30,120	\$ 30,121	& Up
	2	\$ -	\$ 20,440	\$ 20,441	\$ 27,185	\$ 27,186	\$ 33,930	\$ 33,931	\$ 40,880	\$ 40,881	& Up
	3	\$ -	\$ 25,820	\$ 25,821	\$ 34,341	\$ 34,342	\$ 42,861	\$ 42,862	\$ 51,640	\$ 51,641	& Up
	4	\$ -	\$ 31,200	\$ 31,201	\$ 41,496	\$ 41,497	\$ 51,792	\$ 51,793	\$ 62,400	\$ 62,401	& Up
	5	\$ -	\$ 36,580	\$ 36,581	\$ 48,651	\$ 48,652	\$ 60,723	\$ 60,724	\$ 73,160	\$ 73,161	& Up
	6	\$ -	\$ 41,960	\$ 41,961	\$ 55,807	\$ 55,808	\$ 69,654	\$ 69,655	\$ 83,920	\$ 83,921	& Up
	7	\$ -	\$ 47,340	\$ 47,341	\$ 62,962	\$ 62,963	\$ 78,584	\$ 78,585	\$ 94,680	\$ 94,681	& Up
	8	\$ -	\$ 52,720	\$ 52,721	\$ 70,118	\$ 70,119	\$ 87,515	\$ 87,516	\$ 105,440	\$ 105,441	& Up
	9	\$ -	\$ 58,100	\$ 58,101	\$ 77,273	\$ 77,274	\$ 96,446	\$ 96,447	\$ 116,200	\$ 116,201	& Up
	10	\$ -	\$ 63,480	\$ 63,481	\$ 84,428	\$ 84,429	\$ 105,377	\$ 105,378	\$ 126,960	\$ 126,961	& Up

FPG: Federal Poverty Guidelines, published by Health and Human Services, effective 1/17/2024
 For families/households with more than 10 persons, add \$5,380 for each additional person

MONTHLY INCOME											
Category	A		B		C		D		E		
FPG	0 - 100%		>100 - 133%		>133 - 166%		>166 - 200%		>200%		
Family Size	1	\$ -	\$ 1,255	\$ 1,256	\$ 1,669	\$ 1,670	\$ 2,083	\$ 2,084	\$ 2,510	\$ 2,511	& Up
	2	\$ -	\$ 1,703	\$ 1,704	\$ 2,265	\$ 2,266	\$ 2,828	\$ 2,829	\$ 3,407	\$ 3,408	& Up
	3	\$ -	\$ 2,152	\$ 2,153	\$ 2,862	\$ 2,863	\$ 3,572	\$ 3,573	\$ 4,303	\$ 4,304	& Up
	4	\$ -	\$ 2,600	\$ 2,601	\$ 3,458	\$ 3,459	\$ 4,316	\$ 4,317	\$ 5,200	\$ 5,201	& Up
	5	\$ -	\$ 3,048	\$ 3,049	\$ 4,054	\$ 4,055	\$ 5,060	\$ 5,061	\$ 6,097	\$ 6,098	& Up
	6	\$ -	\$ 3,497	\$ 3,498	\$ 4,651	\$ 4,652	\$ 5,804	\$ 5,805	\$ 6,993	\$ 6,994	& Up
	7	\$ -	\$ 3,945	\$ 3,946	\$ 5,247	\$ 5,248	\$ 6,549	\$ 6,550	\$ 7,890	\$ 7,891	& Up
	8	\$ -	\$ 4,393	\$ 4,394	\$ 5,843	\$ 5,844	\$ 7,293	\$ 7,294	\$ 8,787	\$ 8,788	& Up
	9	\$ -	\$ 4,842	\$ 4,843	\$ 6,439	\$ 6,440	\$ 8,037	\$ 8,038	\$ 9,683	\$ 9,684	& Up
	10	\$ -	\$ 5,290	\$ 5,291	\$ 7,036	\$ 7,037	\$ 8,781	\$ 8,782	\$ 10,580	\$ 10,581	& Up

FPG: Federal Poverty Guidelines, published by Health and Human Services, effective 1/17/2024
 For families/households with more than 10 persons, add \$448 for each additional person

What Am I Responsible to Pay?

	A	B	C	D	E
Medical & Clinical Pharmacy Services	\$25	\$35	\$40	\$45	100% of Full Charges
Reproductive Health Services	\$0	Ask for a copy of the Reproductive Health Services Discount Schedule .			
Dental Services*	\$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health Services	\$5	\$10	\$15	\$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	\$5 Dispensing Fee + Discounted Medication Cost	\$8 Dispensing Fee + Discounted Medication Cost	\$10 Dispensing Fee + Discounted Medication Cost	\$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

*\$25 minimum payment required at the time of service (can be waived in cases of financial hardship). Dental supplies and equipment are not included in the Sliding Fee Discount.

**Patients encouraged to ask their Pharmacist for a quote. Call 503-941-3160 for more information.

NEIGHBORHOOD HEALTH CENTER 2024 SLIDING FEE DISCOUNT SCHEDULE - REPRODUCTIVE HEALTH PROGRAM SERVICES

ANNUAL INCOME																							
Category	A		B		C		D		E		F		G		H		I		J		K		
Payment	0%		10%		20%		30%		40%		50%		60%		70%		80%		90%		100%		
FPG	0 - 100%		>100 - 117%		>117 - 133%		>133 - 150%		>150 - 167%		>167 - 185%		>185 - 200%		>200 - 217%		>217 - 233%		>233 - 250%		>250%		
Family Size	1	\$ -	\$ 15,060	\$ 15,061	\$ 17,620	\$ 17,621	\$ 20,030	\$ 20,031	\$ 22,590	\$ 22,591	\$ 25,150	\$ 25,151	\$ 27,861	\$ 27,862	\$ 30,120	\$ 30,121	\$ 32,680	\$ 32,681	\$ 35,090	\$ 35,091	\$ 37,650	\$ 37,651	& Up
	2	\$ -	\$ 20,440	\$ 20,441	\$ 23,915	\$ 23,916	\$ 27,185	\$ 27,186	\$ 30,660	\$ 30,661	\$ 34,135	\$ 34,136	\$ 37,814	\$ 37,815	\$ 40,880	\$ 40,881	\$ 44,355	\$ 44,356	\$ 47,625	\$ 47,626	\$ 51,100	\$ 51,101	& Up
	3	\$ -	\$ 25,820	\$ 25,821	\$ 30,209	\$ 30,210	\$ 34,341	\$ 34,342	\$ 38,730	\$ 38,731	\$ 43,119	\$ 43,120	\$ 47,767	\$ 47,768	\$ 51,640	\$ 51,641	\$ 56,029	\$ 56,030	\$ 60,161	\$ 60,162	\$ 64,550	\$ 64,551	& Up
	4	\$ -	\$ 31,200	\$ 31,201	\$ 36,504	\$ 36,505	\$ 41,496	\$ 41,497	\$ 46,800	\$ 46,801	\$ 52,104	\$ 52,105	\$ 57,720	\$ 57,721	\$ 62,400	\$ 62,401	\$ 67,704	\$ 67,705	\$ 72,696	\$ 72,697	\$ 78,000	\$ 78,001	& Up
	5	\$ -	\$ 36,580	\$ 36,581	\$ 42,799	\$ 42,800	\$ 48,651	\$ 48,652	\$ 54,870	\$ 54,871	\$ 61,089	\$ 61,090	\$ 67,673	\$ 67,674	\$ 73,160	\$ 73,161	\$ 79,379	\$ 79,380	\$ 85,231	\$ 85,232	\$ 91,450	\$ 91,451	& Up
	6	\$ -	\$ 41,960	\$ 41,961	\$ 49,093	\$ 49,094	\$ 55,807	\$ 55,808	\$ 62,940	\$ 62,941	\$ 70,073	\$ 70,074	\$ 77,626	\$ 77,627	\$ 83,920	\$ 83,921	\$ 91,053	\$ 91,054	\$ 97,767	\$ 97,768	\$ 104,900	\$ 104,901	& Up
	7	\$ -	\$ 47,340	\$ 47,341	\$ 55,388	\$ 55,389	\$ 62,962	\$ 62,963	\$ 71,010	\$ 71,011	\$ 79,058	\$ 79,059	\$ 87,579	\$ 87,580	\$ 94,680	\$ 94,681	\$ 102,728	\$ 102,729	\$ 110,302	\$ 110,303	\$ 118,350	\$ 118,351	& Up
	8	\$ -	\$ 52,720	\$ 52,721	\$ 61,682	\$ 61,683	\$ 70,118	\$ 70,119	\$ 79,080	\$ 79,081	\$ 88,042	\$ 88,043	\$ 97,532	\$ 97,533	\$ 105,440	\$ 105,441	\$ 114,402	\$ 114,403	\$ 122,838	\$ 122,839	\$ 131,800	\$ 131,801	& Up
	9	\$ -	\$ 58,100	\$ 58,101	\$ 67,977	\$ 67,978	\$ 77,273	\$ 77,274	\$ 87,150	\$ 87,151	\$ 97,027	\$ 97,028	\$ 107,485	\$ 107,486	\$ 116,200	\$ 116,201	\$ 126,077	\$ 126,078	\$ 135,373	\$ 135,374	\$ 145,250	\$ 145,251	& Up
	10	\$ -	\$ 63,480	\$ 63,481	\$ 74,272	\$ 74,273	\$ 84,428	\$ 84,429	\$ 95,220	\$ 95,221	\$ 106,012	\$ 106,013	\$ 117,438	\$ 117,439	\$ 126,960	\$ 126,961	\$ 137,752	\$ 137,753	\$ 147,908	\$ 147,909	\$ 158,700	\$ 158,701	& Up

FPG: Federal Poverty Guidelines, published of Oregon Reproductive Health Access Fund 03/01/2024

For families/households with more than 10 persons, add \$13,450 for each additional person.

MONTHLY INCOME																							
Category	A		B		C		D		E		F		G		H		I		J		K		
Payment	0%		10%		20%		30%		40%		50%		60%		70%		80%		90%		100%		
FPG	0 - 100%		>100 - 117%		>117 - 133%		>133 - 150%		>150 - 167%		>167 - 185%		>185 - 200%		>200 - 217%		>217 - 233%		>233 - 250%		>250%		
Family Size	1	\$ -	\$ 1,255	\$ 1,256	\$ 1,469	\$ 1,470	\$ 1,670	\$ 1,671	\$ 1,883	\$ 1,884	\$ 2,096	\$ 2,097	\$ 2,322	\$ 2,323	\$ 2,510	\$ 2,511	\$ 2,724	\$ 2,725	\$ 2,925	\$ 2,926	\$ 3,138	\$ 3,139	& Up
	2	\$ -	\$ 1,704	\$ 1,705	\$ 1,993	\$ 1,994	\$ 2,266	\$ 2,267	\$ 2,555	\$ 2,556	\$ 2,845	\$ 2,846	\$ 3,152	\$ 3,153	\$ 3,407	\$ 3,408	\$ 3,697	\$ 3,698	\$ 3,969	\$ 3,970	\$ 4,259	\$ 4,260	& Up
	3	\$ -	\$ 2,152	\$ 2,153	\$ 2,518	\$ 2,519	\$ 2,862	\$ 2,863	\$ 3,228	\$ 3,229	\$ 3,594	\$ 3,595	\$ 3,981	\$ 3,982	\$ 4,304	\$ 4,305	\$ 4,670	\$ 4,671	\$ 5,014	\$ 5,015	\$ 5,380	\$ 5,381	& Up
	4	\$ -	\$ 2,600	\$ 2,601	\$ 3,042	\$ 3,043	\$ 3,458	\$ 3,459	\$ 3,900	\$ 3,901	\$ 4,342	\$ 4,343	\$ 4,810	\$ 4,811	\$ 5,200	\$ 5,201	\$ 5,642	\$ 5,643	\$ 6,058	\$ 6,059	\$ 6,500	\$ 6,501	& Up
	5	\$ -	\$ 3,049	\$ 3,050	\$ 3,567	\$ 3,568	\$ 4,055	\$ 4,056	\$ 4,573	\$ 4,574	\$ 5,091	\$ 5,092	\$ 5,640	\$ 5,641	\$ 6,097	\$ 6,098	\$ 6,615	\$ 6,616	\$ 7,103	\$ 7,104	\$ 7,621	\$ 7,622	& Up
	6	\$ -	\$ 3,497	\$ 3,498	\$ 4,092	\$ 4,093	\$ 4,651	\$ 4,652	\$ 5,245	\$ 5,246	\$ 5,840	\$ 5,841	\$ 6,469	\$ 6,470	\$ 6,994	\$ 6,995	\$ 7,588	\$ 7,589	\$ 8,148	\$ 8,149	\$ 8,742	\$ 8,743	& Up
	7	\$ -	\$ 3,945	\$ 3,946	\$ 4,616	\$ 4,617	\$ 5,247	\$ 5,248	\$ 5,918	\$ 5,919	\$ 6,589	\$ 6,590	\$ 7,299	\$ 7,300	\$ 7,890	\$ 7,891	\$ 8,561	\$ 8,562	\$ 9,192	\$ 9,193	\$ 9,863	\$ 9,864	& Up
	8	\$ -	\$ 4,394	\$ 4,395	\$ 5,141	\$ 5,142	\$ 5,844	\$ 5,845	\$ 6,590	\$ 6,591	\$ 7,337	\$ 7,338	\$ 8,128	\$ 8,129	\$ 8,787	\$ 8,788	\$ 9,534	\$ 9,535	\$ 10,237	\$ 10,238	\$ 10,984	\$ 10,985	& Up
	9	\$ -	\$ 4,842	\$ 4,843	\$ 5,665	\$ 5,666	\$ 6,440	\$ 6,441	\$ 7,263	\$ 7,264	\$ 8,086	\$ 8,087	\$ 8,958	\$ 8,959	\$ 9,684	\$ 9,685	\$ 10,507	\$ 10,508	\$ 11,282	\$ 11,283	\$ 12,105	\$ 12,106	& Up
	10	\$ -	\$ 5,290	\$ 5,291	\$ 6,190	\$ 6,191	\$ 7,036	\$ 7,037	\$ 7,935	\$ 7,936	\$ 8,835	\$ 8,836	\$ 9,787	\$ 9,788	\$ 10,580	\$ 10,581	\$ 11,480	\$ 11,481	\$ 12,326	\$ 12,327	\$ 13,225	\$ 13,226	& Up

FPG: Federal Poverty Guidelines, published of Oregon Reproductive Health Access Fund 03/01/2024

For families/households with more than 10 persons, add \$1,121 for each additional person.