



Central Montana Family Planning

505 West Main St, Suite 108
Lewistown, MT 59457
(406) 535-8811 phone & fax
<http://www.cmtfp.org>

PARENTAL INSURANCE CONSENT

Your child has informed us that you are aware of their being seen at our facility for medical services.

Our charges are based on family size and gross income. Your signature below permits us to evaluate your child for a possible discount for their fees. Please provide the following:

_____ I elect to provide the requested information:

Family Size: _____

Total Gross Monthly Income: _____

Total Gross Yearly Income: _____

Insurance Company: _____

Group Number: _____

Subscriber ID: _____

Subscriber Name: _____

Parent/Guardian Signature

Date

SIGN HERE

_____ I do not wish to provide the requested information and prefer my child be responsible for their own charges.

Parent/Guardian Signature

Date

SIGN HERE

If you have any questions regarding this form or how we charge our patients please don't hesitate to call.

Patient Name: _____ Date of Birth: _____