



## Madison Free Clinic Patient Agreement

I, \_\_\_\_\_, agree to keep my Madison Free Clinic status up to date. I understand I could incur medical/dental/vision bills from the Providers the Free Clinic is partnered with if my status is expired. I understand I need to update my financial information once every 6 months, to stay active with the Clinic. I agree to update the Clinic if anything changes with my finances, medical insurance, phone number or residency.

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

Date: \_\_\_\_\_