Pediatric Partners of Zephyrhills
Discounted/Sliding Fee Application

It is Pediatric Partners' policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received in the office but not those services which are purchased from outside such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. **In the hope that your economic health improves, <u>discounts apply only to current, not future services</u>. This form must be completed for each visit. Please inquire at the front desk if you have questions.**

Name of Head of Household		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

Name (Print) _____

Signature/Date _____

Office Use Only

Pay Class Approved: _____ Effective Date: _____

Approved By: _____ Expiration Date _____

PLEASE READ

If I have requested a Discounted Fee based on Income and Family Size as I am not covered by insurance, I agree that I will return this completed application with the required proof of family income within two weeks and that any discount that I may qualify for will be applied and the difference, if applicable, will be refunded to me. Otherwise, I agree that I am responsible for the full amount of the visit charges and relinquish my right to a discount.