Sliding Fee Discount Information

It is the policy of My Primary Care to provide essential services regardless of the patient's ability to pay. My Primary Care offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for this discount.

The discount will apply to all Primary Care services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, medications, x-rays and X-ray interpretation by a consulting radiologist, or other such services. You must complete this form every 12 months and/or when your financial situation changes.

NAME				
STREEET	CITY	STATE	ZIP	PHONE

List all household members, including those under age 18.

Relationship	NAME	Date of Birth
Self		

Source	Self	Other	Total
Gross Wages, Salaries, Tips, Ect....			
Income from Business and Self-Employment			
Unemployment compensation, Workers Compensation			
Social Security, Supplemental Security Income, Veterans' Payments, Survivor Benefits, Pension or Retirement Income			
Interest; dividends; royalties; income from rental properties, estates, & trusts; alimony; child support; assistance from outside the household; & other miscellaneous sources			

I certify that the family size and income information shown above is correct.

Name (Print): _____

Signature: _____ Date: _____

OFFICE USE ONLY

Patient Name: _____
Approved Discount: _____
Approved By: _____
Date Approved: _____
Rejected Date: _____

VERIFICATION CHECKLIST	YES	NO
Identification: Drivers License, Utility Bill, Employment ID or other _____		
Income: Prior Year Tax Return, Three most recent Pay Stubs, or other _____		