FAIRCHILD MEDICAL CENTER

Sliding Fee Application

It is the policy of Fairchild Medical Clinic(s) to provide essential services regardless of the patient's ability to pay. Sliding Fee discounts are approved based upon family size and income. Please complete the following information and return this application to the front desk, to determine if you or members of your family are eligible for a sliding fee discount.

The discount will apply to all services received at the clinic(s), with the exception of laboratory, x-ray services or non-Fairchild Medical Clinic services such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist or similar services. Payment must be made within 30 days of the statement date. If payment is not received within 30 days of the statement date, the discount will not be given. This application is valid for one year from initial date of service. Please inquire at the Registration desk if you have any questions.

Number of dependent persons living in your household: _____

Total Household Income:

Household Member	Household Annual Income
Self	
Spouse	
Dependents	
Total:	

Note: Include income from all related persons in household and income from all sources, including gross wages, tips, Social Security benefits, disability, pensions, annuities, Veterans payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

I certify that all information provided above is true and correct.

_____

_____

Name (Print) Signature Date

Office Use Only

Patient Name: _____ Discount: _____

Date of Service: _____ Approved by (Print Name): _____