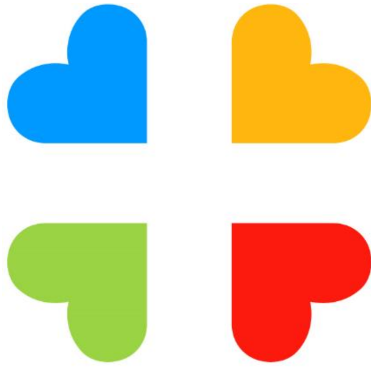

North Florida
Pediatrics

# Sliding Fee Application

Please complete all portions of this application. Note that this is only an application, and your eligibility will be determined by North Florida Pediatrics' sliding fee discount policy. This is based on your annual household income and family size.

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| Patient Information | | |
|---|---|---|
| **Date:** | **Primary NFP Office: Check One**<br>**Lake City ___Live Oak___Jasper ___City____Chiefland___Starke__Bay Meadows__San Marco__Nocatee** | |
| **First Name:** | **Middle Name:** | **Last Name:** |
| **DOB:** | | **Does the patient have any health insurance?**<br>☐ **Yes** ☐ **No** |

| Parent/Guardian Information | | |
|---|---|---|
| **First Name:** | **Middle Name:** | **Last Name:** |
| **DOB:** | | |
| **Home Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Billing Address (If different than above):** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** |
| **Marital Status:** ☐ **Single** | ☐ **Married** ☐ **Divorced** | ☐ **Separated** ☐ **Widowed** |

| **Household Size-** Please list all individuals living in the home with the patient | | |
|---|---|---|
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |
| **Name:** | **DOB:** | **Relationship:** |

| Household Employment Income | | | | | | |
|---|---|---|---|---|---|---|
| **Name** | **Amount** | **Employer** | **Frequency** | | | |
| **Parent (You)** | **$** | | ☐ **Weekly** | ☐ **Biweekly** | ☐ **Monthly** | ☐ **Yearly** |
| **Other Parent** | **$** | | | | | |
| **Child** | **$** | | | | | |
| **Other** | **$** | | | | | |
| **Other** | **$** | | | | | |
| **Total:** | **$** | | | | | |

| Monthly Household Income | | | | | |
|---|---|---|---|---|---|
| **Source** | **Parent (You)** | **Other Parent** | **Child** | **Other** | **Subtotal** |
| **Social Security** | **$** | **$** | **$** | **$** | **$** |
| **Retirement Pension** | **$** | **$** | **$** | **$** | **$** |
| **Child Support** | **$** | **$** | **$** | **$** | **$** |
| **Alimony** | **$** | **$** | **$** | **$** | **$** |
| **Other** | **$** | **$** | **$** | **$** | **$** |
| **Total:** | | | | | **$** |

**By Signing below, I acknowledge the following:**
To comply with federal regulations and to give you a discount on your medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file in strict confidentiality. You must reapply every six months to determine your continued eligibility. The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services.

By signing below, I affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsifying information, and/or admissions may disqualify me from further consideration for the sliding fee program. I further agree to inform North Florida Pediatrics, P.A. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all the rules and regulations of North Florida Pediatrics, P.A. I hereby acknowledge that I have read the forgoing disclosure and understand it.

| **Signature:** | **Print Name:** | **Date:** |
|---|---|---|

| **Acknowledgement of Receipt of Offer of Sliding Fee Application** |
|---|
| By signing below, I acknowledge that I was offered by North Florida Pediatrics the opportunity to apply for their sliding fee program. I understand that this is merely an offer, and that I have the option to apply for the sliding fee program or decline the opportunity to apply.<br><br>Please Check one:<br><br>☐ I **ACCEPT** the opportunity to apply for the sliding fee program.<br>☐ I **DECLINE** the opportunity to apply for the sliding fee program. |

| **Signature:** | **Print Name:** | **Date:** |
|---|---|---|

| **Patient name:** | **Date of Birth:** |
|---|---|

**Office Use Only:**

| **Application Reviewed by (Front Desk Employee):** | **Date:** |
|---|---|

| **Application Verified by (Billing Dept Employee):** | **Date:** |
|---|---|
| ☐ Approved<br><br>☐ Denied reason: ______________________________________________ | |