



**North Florida
Pediatrics**
Sliding Fee Application

“This form must be witnessed and signed by a North Florida Pediatrics staff member”

Please 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 the household size and annual income. Please complete all portions and submit proof of income as necessary. *****ONLY ONE APPLICATION PER HOUSEHOLD (FAMILY)*****

Patient Information		
Date:	Primary Office: Please circle one Lake City - Live Oak - Jasper - Chiefland - Cross City - Starke - Baymeadows - San Marco - Nocatee - Mandarin	
First Name:	Middle Name:	Last Name:
DOB:	Does the patient have any health insurance? YES () NO ()	

Parent/Guardian Information			
First Name:	Middle Initial:	Last Name:	DOB:
Home Address:			
City:	State:	Zip Code:	
Billing Address:			
City:	State:	Zip Code:	
Home Phone:	Cellphone:	Work phone:	
Marital Status:	Married ()	Separated ()	Divorced () Single () Widow ()
How many household members live in the house, including the patient? Total Number:			

*****PLEASE LIST ON THE FOLLOWING PAGE ANY SIBLING INFORMATION*****

Total Household Monthly Income	
NOTE: Including salary, Social Security, Retirement Pension, Food Stamps, Child Support, and other sources of income.	
Guardian/Parent 1: \$ _____ / monthly	Guardian/Parent 2: \$ _____ / monthly
Overall Total Household Income: \$ _____ / monthly	

<p>By signing below, I acknowledge the following: To comply with federal regulations and to offer me a discount on my medical services, North Florida Pediatrics, P.A. must ask personal questions. My answers will be kept on file with strict confidentiality. I must reapply every six months to determine my continued eligibility. My household size and income will determine my eligibility for this benefit, and I may bring any of the following proof of income (household’s current income tax return, a copy of W2 forms, last month’s paystubs, approval letter/form with SSA/SSI annual income, or any other proof of income received in the household) as necessary. I affirm that the information provided on this application is true and correct to the best of my knowledge and beliefs. I agree that any misleading or falsified information, and/or admission may disqualify me from further consideration for the sliding fee program. I further agree to inform North Florida Pediatrics P.A. of any significant change in my income. If acceptance of 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 foregoing disclosure and understand it.</p>		
Signature:	Print Name:	Date:



Acknowledgment of Receipt of Offer of Sliding Fee Application

By signing below, I acknowledge that I was offered by North Florida Pediatrics 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.

Please check one:

- I ACCEPT the opportunity to apply for the sliding fee program**
- I DECLINE the opportunity to apply for the sliding fee program**

Signature:	Printed Name:	Date:
Patient Name:	DOB:	

Sibling Name:	Sibling DOB:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

NOTE: This section is for North Florida Pediatrics staff only.

OFFICE USE ONLY	
Application Reviewed by: (Front Desk Employee): _____	Date: _____
Application Verified by: (Billing Dept. Employee): _____	Date: _____
<input type="radio"/> Approved <input type="radio"/> Denied / Reason: _____	Date: _____