

Sliding Fee Discount Application

It is the policy of Piedmont Pediatrics of Laurens County to provide essential services regardless of the patient's ability to pay. Piedmont Pediatrics of Laurens County offers discounts based on family size and annual income.

Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount. We will need a form of identification/address, such as: driver's license, utility bill, employment identification or other. We prefer to have proof of income, such as: prior year tax return or three most recent pay stubs, but self declaration of income may also be used.

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. You must complete this form every 12 months or if your financial situation changes.

| | | | | |
|---------------|-------------|--------------|------------|--------------|
| NAME | | | | |
| STREET | CITY | STATE | ZIP | PHONE |
| | | | | |

Please list all household members, including those under age 18.

| | NAME | DATE OF BIRTH |
|-------|------|---------------|
| SELF | | |
| OTHER | | |
| OTHER | | |
| OTHER | | |
| OTHER | | |
| OTHER | | |

| SOURCE | Self | Other | TOTAL |
|--|------|-------|-------|
| Gross wages, salaries, tips, etc. | | | |
| Income from business and self-employment | | | |
| Unemployed compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income | | | |
| Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources | | | |
| TOTAL INCOME | | | |

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: _____

| Verification Checklist | Yes | No |
|---|-----|----|
| Identification/Address: Driver's License, utility bill, employment identification, or other | | |
| Income: prior year tax return, three most recent pay stubs, or other | | |

Self declaration of income may also be used.