Grinstead, Pierce & Associates

Real Solutions to Fit Your Needs

Sliding Fee Scale Application

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Place of employment:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Annual Household Income	You	Spouse	Children	Total
Gross wages, salaries, tips, etc.				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income.				
Total Income				

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Sliding Fee Scale:

A – 80% Discount

B – 60% Discount

C – 40% Discount

D – 20% Discount

E – 0%Discount

I do hereby swear or 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 falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Grinstead, Pierce and Associates 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 rules and regulations of Grinstead, Pierce and Associates. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by:_____

Date Approved:_____

Verification:

Identification/Address: Driver's License, utility bill, employment ID or other Yes/ No

Income: Prior year tax return, three most recent pay stubs or other Yes/ No

Insurance: Insurance Cards Yes/ No