Palms Medical Group
Your home for health, wellness, life

SLIDING FEE SCALE APPLICATION

It is the policy of Palms Medical Group to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

Name of Head of Household		Place of Employment		
Mailing Address	City	State	Zip	Phone
Total Number of Adult Family Members		Total Number of Children Family Members:		

Annual Family Income

Source	Self	Spouse	Other	Total
Gross Wages, Salaries, tips, Prior Year Tax Return				
Income from Business, self-employment and dependents				
Unemployment Compensation, Worker's Compensation, Social Security Supplemental Security Income, Public Assistance, Veteran's Payments, Survivor benefits, Pension or Retirement Income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.				
Total Income				

Note: Copies of prior year tax returns, three most recent pay stubs or other information verifying income is required before discount is approved.

I certify that the family size and income information shown above is correct.

Signature_____ **Date:**_____

Board Approved

FOR OFFICE USE ONLY

Patient Name: _____ Patient DOB #_____

SF Discount Approved Category: _____ SF Expiration: _____ Patient Acc #_____

Approved by: _____

Date Approved: _____

Sliding Fee Schedule - Patient Payment Responsibility					
Slide	Medical	Chiropractic	Behavioral Health	Dental	
A	$20-Nominal Charge	$30-Nominal Charge	$30-Nominal Charge	$35-Preventative Nominal Charge $50 Non-Preventative Nominal Charge	
B	$30-Patient Responsibility	$40- Patient Responsibility	$40- Patient Responsibility	70% of all Charges- Patient Responsibility	
C	$40- Patient Responsibility	$50- Patient Responsibility	$50- Patient Responsibility	80% of all Charges- Patient Responsibility	
D	$50- Patient Responsibility	$60- Patient Responsibility	$60-C Patient Responsibility	90% of all Charges - Patient Responsibility	

SLIDING FEE SCALE PROGRAM RULES OF PARTICIPATION

Your application will NOT be processed without the requested information. Any information given to Palms Medical Group will be kept confidential. If the information proves FRAUDULENT we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits.

Before you sign up on the Sliding Fee Scale Program please read the following rules.

THESE RULES MUST BE FOLLOWED WITHOUT EXCEPTION:

1. **PALMS MEDICAL GROUP. MUST BE NOTIFIED IMMEDIATELY IF:**
   - a. **There is a change of income of any family member in the household**
   - b. **Any member of the household obtains insurance of any kind.**
   - c. **There is a change in the number of family members within the household.**
   - d. **There is a change in mailing address.**
2. **YOU MUST PAY YOUR CALCULATED FEE AT THE TIME OF EACH VISIT.**

If you do not pay your calculated fee at the time of service, you must pay the balance of your account within 15 working days after receiving a statement. If payment is not received within 90 days, Palms medical Group reserves the right to TERMINATE your eligibility in the Sliding Fee Scale Program and pursue further collection efforts.

I, _____, have read the above rules and agree to follow them. I also understand that if I do not comply with the rules set forth, my participation in the program will be terminated.

APPLICANT'S SIGNATURE DATE

EXAMINER'S SIGNATURE DATE

Board Approved