BRAY
FAMILY
MEDICINE

Sample Sliding Fee Discount Application

Sliding Fee Discount Information

It is the policy of Bray Family Medicine to provide essential services regardless of the patient's ability to pay. Bray Family Medicine offers discounts 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.

The Sliding Fee Discount Program applies only to visits with a Bray Family Medicine provider (physician, physician assistant, nurse practitioner or counselor). All other Bray Family Medicine services including lab, injections and x-rays are offered at set discounted rates for all patients. A detailed list of these fees is attached to this application and will also be available upon request. If any of these additional services are indicated, the exact amount of each additional service will be provided for your approval before the service is rendered.

NAME		**PLACE OF EMPLOYMENT**		
STREET	**CITY**	**AR**	**ZIP**	**PHONE**

Please list spouse and dependents under age 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

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SOURCE	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' 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 tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

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

NAME (Print) _____

SIGNATURE _____DATE_____

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Office Use Only

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

Patient Name: _____

Approved discount: _____

Approved by: _____

Date approved: _____