The Purcell Clinic

~ Pediatrics – Adolescent Medicine ~

418 S. King St.
Laurinburg, NC 28352
910-276-7570

Sliding Fee Discount Application

It is the policy of The Purcell Clinic 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 patient account representative to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Head of Household: First Name_____ Last Name_____ Phone Number_____ **Employment:** Employer: _____ Phone Number: _____	**Address:** Street_____ City_____ State_____ Zip_____ **Patient:** First Name_____ Last Name_____ Date of Birth: _____

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF:		DEPENDENT:	
SPOUSE:		DEPENDENT:	
DEPENDENT:		DEPENDENT:	
DEPENDENT:		DEPENDENT:	

Annual Household Income 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: Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. **Self-declaration of Income** may only be used in special circumstances. Specific examples include participants who have no income. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to The Purcell Clinic's Office Manager or the Patient Account Representative for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

By signing the Sliding Fee Discount Program application, you authorize The Purcell Clinic access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

By signing this form, I certify that I have received a copy and understand The Purcell Clinic's Sliding Fee Discount Program Policy.

I certify that the information on this form and submitted documentation is correct to the best of my knowledge.

Print Name: _____

Signature: _____ Date: _____