It is the policy of Haywood Pediatric & Adolescent Medicine Group, PA 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 it to the front desk 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.

NAME: _____

ADDRESS (STREET,CITY,STATE,ZIP): _____

_____

PHONE: Home: _____ Cell: _____ Other : _____

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

NAME Date of Birth

SELF: _____

OTHER:_____

OTHER:_____

OTHER:_____

OTHER:_____

OTHER:_____

ANNUAL HOUSEHOLD INCOME

Source	Self	Other	Total
Gross wages, salaries, tips, etc			
Income from business, self-employment, and dependents			
Unemployment 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 ID, or other	_____	_____
Income: Prior year tax return, three most recent pay stubs, or other (Self-declaration of income may also be used)	_____	_____