HEARTLAND PEDIATRICS
Newborns, Children & Adolescents

Dear Parent:

It is our office policy to provide essential services regardless of the patient's ability to pay for our patients who fall within the federal poverty guidelines. Discounts are offered depending upon family income and size. The discount will apply to all professional services rendered at this office only.

Today you were given the discounted sliding fee of _____, for _____ poverty level, which is our discounted fee.

Discounts apply only to current, not future services. **ON YOUR NEXT VISIT TO OUR CLINIC, IN ORDER TO CONTINUE QUALIFYING FOR THE DISCOUNTED SLIDING FEE, WE REQUEST YOU TO BRING IN THE FOLLOWING:**

1. A copy of your latest income tax return. OR

2. Four (4) payroll stubs of recent paychecks (parents or guardians)

Your discount status will be re-evaluated for eligibility on a monthly basis. In the hope that your economic situation improves, each month you will be requested to bring in the items listed above to continue participating in our discount sliding fees.

Our office is committed to providing quality care regardless of race, ethnicity, religion, national origin and or financial status etc.

If your child becomes eligible for Medicaid on the date of his/her visit, the sliding fee paid by you will be refunded to you. Please inquire at the front desk if you have any questions.

Sincerely,

Management

Discounted / Sliding Fee Application

It is our office policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or member so your family are eligible for a discount.

The discount will apply to all services received at the center but not those services which are purchased from outside such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _____

Total household income: (complete one column)

Household Member	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Relatives			
Total			

Note: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid and other.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

_____ _____

Name (Print) Signature/Date

Office Use Only

Patient Name _____ Discount _____

Date of Service _____ Approved by _____