SANDHILLS MEDICAL FOUNDATION, Inc.

Sliding Fee Policy Certification

Patient Name: _____

ALL SLIDING FEE APPLICANTS PLEASE READ AND SIGN THE FOLLOWING:

The policy concerning the sliding fee program reads that the applicant has to bring the proof of income. I understand that it is my responsibility to supply all requested information by my second visit. If I do not supply this information, I will be taken off the sliding fee until such information is submitted and will be responsible for paying full charges at the time of service.

I also understand that I must inform Sandhills Medical Foundation, Inc. if I or anyone in my household becomes covered by any health insurance policy. Sandhills Medical Foundation, Inc. has my permission to bill any eligible insurance.

I, _____, understand the updated policy for all sliding fee applicants. I agree to comply with this policy.

Signature:	Date:	**Clinic purpose only** clerk initials: