SANDHILLS MEDICAL FOUNDATION, Inc.

Sliding Fee Policy Certification

Patient Name (Please Print):_____

ALL SLIDING FEE APPLICANTS PLEASE READ AND SIGN THE FOLLOWING:

The policy concerning the sliding fee program reads that the applicant has to bring in their proof of income within 14 days. If I do not supply this information in the allotted time, I will have to submit both a new application along with proof of income. No discounts will be given until this is complete, and discounts will not be given on visits prior to the new application date.

I also understand that if my income should change that I am required to notify the receptionist during my next visit to the clinic. I also understand I must recertify every twelve months.

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:	Staff initials: