

First Coast Obstetrics & Gynecology
7000 Old Wolf Bay Rd
Palatka, FL 32177

First Coast Obstetrics & Gynecology Sliding Fee Schedule Discount Application

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical health needs. This information will not be used to withhold or deny services to you.

Patient Information:

Name: _____ Telephone number: _____
Address: _____ Date of birth: _____
City: _____ State: _____ Zip
code: _____

Applicant (Guarantor) Information:

____ Please check, if the information is the same as above. If not please proceed below:

Relationship to patient: ___Self ___Parent/Guardian

Name: _____ Date of birth _____

SSN: _____ Telephone number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Please answer questions below and circle yes or no

Are you covered under Medicare, Medicaid and/or any other insurance? **Yes No**

If you have private insurance, what is your out of pocket expense? \$ _____

Have you or your family ever applied for or been denied for Medicaid or Medicare? **Yes No**

Are you unemployed? **Yes No**

Are you too sick to work or are you disabled? **Yes No**

Source	Self	Spouse	Other	Weekly,Bi-weekly, Part-time or full-time	Total
Gross Wages, salaries, tips, etc					
Income from business, self-employment, and dependents					
Unemployment Compensation, Worker's Compensation, Social Security Income, public assistance, Veteran's 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					

Patient Acknowledgement statement

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage; I will contact/notify the facility. I understand that I will be financially responsible for all or portion of my care and that I will be asked to submit payment at the time of service. I authorize the release of any information necessary to establish my eligibility for discounted services.

Patient

Signature: _____ Date _____

Print Name: _____

Verification Checklist

	Yes	No
Identification/Address: Driver's License, Utility Bill, Employment ID, or other		
Income: Prior Year Return, 3 most recent pay stubs, or other		
Insurance: Insurance Cards		

Medicaid Evidence of Rejection	Yes	No	Medicaid Application Made	Yes	No
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Office Use Only

<i>Discount?</i>	<i>Yes ___%, \$___, No</i>
<i>Decision Date</i>	
<i>PAR Signature</i>	