DISCOUNTED/SLIDING FEE APPLICATION

It is Sprout Dental's policy to provide essential dental services regardless of the patient/family's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and return 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 provided at Sprout Dental, but not those services which are purchased from outside vendors, including reference laboratory testing, prescription drugs, and x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation 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 _____

_____ _____

Name of Head of Household **Patient Name (Print)**

_____ _____

Address **Phone**

_____ _____

Health Insurance Plan (If applicable) **Social Security Number**

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-weekly
Self			
Spouse			
Dependent Minor			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

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

_____ _____

Name (Print) **Signature**

_____ _____

Patient Name **Date**

FOR OFFICE USE ONLY

☐ **ID/ADDRESS** ☐ **INCOME VERIFICATION** ☐ **INSURANCE**

☐ **MEDICAID: APPLICATION OR PROOF OF REJECTION**

_____ _____

Patient Name **Discount**

_____ _____

Date **Approved By**

sproutdental.com