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Erlanger Murphy Group Practice P.O. Box 950 * Murphy, NC * 28906

Location: Andrews Hayesville Murphy Gen Surg Urology Ortho Peachtree

ERLANGER MURPHY GROUP PRACTICE SLIDING FEE DISCOUNT APPLICATION

It is the policy of Erlanger Murphy Group Practice to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family 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 received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME: PATIENT ACCOUNT #	M	IFDTCAL DI	FCORD #	<u> </u>		
		ILDICAL KI	LCORD #			
	RESP	ONSIBLE F	PARTY			
NAME OF HEAD OF HOUSEHOLD						DATE OF BIRTH
STREET ADDRESS, CITY, STATE, ZIP		HOW LONG ADDRESS	AT THIS		HOME PHONE	
EMPLOYER NAME AND ADDRESS			BUSINESS PHONE		LENGTH OF EMPLOYMENT	
HEALTH INSURANCE NAME		POLICY HOLDER			EFFECTIVE DATES	
		SPOUSE				
NAME						
EMPLOYER NAME AND ADDRESS		BUSINESS PHONE		LENGTH OF EMPLOYMENT		
HOUSEHOLD	INFORM	ATION (DE	PENDEN	TS UND	ER AGE 18)	
NAME	D	ОВ			RELATIONSHIP)

SOURCE	SELF	SPOUSE	OTHER	T
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
nterest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				
Incomplete or fraudulent applications will be denied. revocation of charity assistance if discovered after it has been application, I hereby a land complete and certify that the family size and income in	en granted. affirm that tl iformation s	ne above stat hown above	ements are is correct.	
Name (Print):				_
Application Date:				_
Relationship If Other Than Patient:				_
				_
Office Use Only	,			
Patient Name:				
Approved Discount:				
Approved By and Date:				

Income: Prior year tax return, three most recent pay stubs, or other

Insurance: Insurance Cards

Total persons in household: