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Sliding Fee Discount Application

It is the policy of Beautiful Dreamers, Ltd., to provide essential services regardless of the patient's ability to pay. Beautiful Dreamers, Ltd., offers discounts based on family size and annual income. Please complete this form and return it to our office. **PLEASE DO NOT LEAVE ANY FIELDS BLANK.**

Please be specific and report information for **Calendar Year 2019, not the current year.**

This discount will apply to services received at the Beautiful Dreamers, Ltd. office, but not those services or equipment purchased from the outside, including reference laboratory testing, drugs, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name of Head of Household____

Place of employment____

Street____

City__________________ State__________________________ Zip______________________

Phone No. (s)____

Please list spouse and dependents under the age of 18:

(Self)____ Date of Birth________________

(Spouse)____ Date of Birth________________

(Dependent)____ Date of Birth________________

(Dependent)____ Date of Birth________________

(Dependent)____ Date of Birth________________

(Dependent)____ Date of Birth________________

(Dependent)____ Date of Birth________________

(Dependent)____ Date of Birth_________________

Please list gross wages, salaries, tips, etc.:
Self:________________
Spouse:_____________
Other_______________
TOTAL:__________

Income from business, self-employment, and dependents:
Self:__________________
Spouse:_______________
Other:________________
TOTAL:___________

Unemployment Compensation, Workers' Compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income:
Self:________________
Spouse:_____________
Other:______________
Total:_________

Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources:
Self:______________
Spouse:___________
Other:____________
Total:_______

TOTAL INCOME:
Self:____________
Spouse:_________
Other:__________

I certify that the family size and income information shown above is correct:

Name (print) ____

Signature ____ Date___________________________

OFFICE USE ONLY

Patient Name: _______________________________________

Approved Discount: __________________________________

Approved by: _______________________________________

Date Approved: _____________________________________

Verification Checklist:
Identification/Address: Driver's License, utility bill, employment ID, or other: YES____ NO ____
Income: Prior year tax return, three most recent pay stubs, or other: YES____ NO_____
Insurance: Insurance Cards: YES ______ NO ______