

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

Location: □ Andrews □ FM Hayesville □ FM Murphy □ Gen Surg □ OB/GYN □ Ortho □ UCC Murphy □ Urology □ 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 #	EDICAL RECORD #											
RESPONSIBLE PARTY												
NAME OF HEAD OF HOUSEHOLD		MARITAL STATUS SOCIA		AL SECURITY#	DATE OF BIRTH							
STREET ADDRESS, CITY, STATE, ZIP		HOW LONG AT THIS ADDRESS		HOME PHONE								
EMPLOYER NAME AND ADDRESS		BUSINESS PHONE		LENGTH OF EMPLOYMENT								
HEALTH INSURANCE NAME		POLICY HOLDER			EFFECTIVE DATES							
		SPOUSE										
NAME					SOCIAL SECURITY#							
EMPLOYER NAME AND ADDRESS		BUSINESS PHONE		LENGTH OF EMPLOYMENT								
HOUSEHOLD	INFORM	ATION (DE	PENDEN	ITS UND	ER AGE 18)							
NAME	DOB				RELATIONSHIP							

OURCE	SELF	SPOUSE	OTHER	7
Gross wages, salaries, tips, etc.				
ncome from business, self-employment, and dependents				
Inemployment compensation, workers' compensation, Social security, Supplemental Security Income, public assistance, eterans' payments, survivor benefits, pension or retirement acome				
nterest, dividends, rents, royalties, income from estates, trusts, ducational assistance, alimony, child support, assistance from utside the household, and other miscellaneous sources				
Total Income				
In completing this financial assistance application, I hereby a and complete and certify that the family size and income inf	offirm that the community of the communi	ne above stat own above is	ements are s correct.	COI
Nama (Print)				
Name (Print):				_
				_
Signature:				_
Name (Print):				_
Signature:				_ _
Signature:Application Date:				_
Signature:Application Date: Relationship If Other Than Patient: Office Use Only				
Application Date: Relationship If Other Than Patient: Office Use Only Patient Name:				
Application Date: Relationship If Other Than Patient: Office Use Only Patient Name: Approved Discount:				_ _
Signature:Application Date: Relationship If Other Than Patient:				
Application Date: Relationship If Other Than Patient: Office Use Only Patient Name: Approved Discount:				

Insurance: Insurance Cards

Total persons in household: