FINANCIAL ASSISTANE FORM

OUR OFFICE VISIT RATES RANGE FROM $105.00 TO $145.00.

BASED ON YOU INCOME YOU MAY QUALIFY FOR OUR DISCOUNT PROGRAM.

THE PERCENT OF YOUR DISCOUNT IS BASED ON YOU INFORMATION, PROCEDURES VARY IN PRICING.

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PARENT OR GUARDIAN NAME: _____

RELATIONSHIP WITH PATIENT: _____

(CHECK ONE THAT APPLYS)

☐ ANNUAL INCOME $0 - $12,000 PER FAMILY

☐ ANNUAL INCOME $12,001 - $16,000 PER FAMILY

☐ ANNUAL INCOME $16,001 - $20,00 PER FAMILY

I, _____ CERTIFY THAT ALL THE INFORMATION IS TRUE AND COMPLETE.
(PARENT OR GUARDIAN NAME)

PARENT OR GAURDIAN SIGNATURE: _____ DATE: _____

RESERVED FOR OFFICE USE ONLY

SIGNATURE (MAMA MIA PEDIATRICS EMPLOYEE):

DISCOUNT