Dr. Peters' Office Sliding Fee Scale Program

Name:_____ Dob:_____

SS#:_____

Sliding Scale Worksheet:

Monthly Income:

a. Unemployment Compensation _____
b. Public Assistance _____
c. Disability _____
d. Child Support and/or Alimony _____
e. Other Income _____

Total monthly income: _____

Total Number of Household Members: _____

By signing below I am acknowledging that I do not have health care coverage.
This agreement is valid from _____to _____.
Determination for this assistance will be reviewed annually.

_____ _____
Signature Date

_____ _____
Printed name Witness

3/15/17