# LEXINGTON FAMILY PHYSICIANS SLIDING FEE DISCOUNT PATIENT APPLICATION

Lexington Family Physicians has a deep commitment to our community and the patients we serve. Likewise, The National Health Service Corps (NHSC) builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care. The NHSC approves sites that provide outpatient, primary health services to areas that are experiencing health professional shortages. Lexington Family Physicians Sliding Fee Schedule Policy is in alignment with these core values of NHSC.

Patients may also download an application from www.lexingtonfamilyphysicians.com and through the patient portal. A printed copy can be obtained at the office front desk. Applications can be returned through the patient portal, fax or mail.

Lexington Family Physicians

102 West Medical Park Drive

Lexington NC 27292

Attention: Discount Fee Program

Please complete the following information and return to our office. This application will be used to determine if you or members of your family are eligible for a discount.

This discount will apply to office visits and office based services. This does not include services from contracted reference labs, diagnostics performed outside of the office or prescriptions/immunizations.

We will work with you to coordinate community services/resources for your prescription or vaccination needs. You may apply for additional discounted services with an NHSC recognition.

Applicant Name: _____

Address: _____

_____

Phone: _____

Please list all members of your household, including those under the age of 18.

| HOUSE HOLD MEMBER(S) | NAME | | DATE OF BIRTH |
|---|---|---|---|
| SELF | | | |
| OTHER | | | |
| OTHER | | | |
| OTHER | | | |
| OTHER | | | |
| OTHER | | | |
| OTHER | | | |
| SOURCE OF INCOME | SELF | OTHER | TOTAL |
| Gross wages,salaries,tips,etc | | | |
| Income from business and self-employment | | | |
| Unemployment, workers 'comp, Social Security Payments, Veterans' payments, survivor benefits, Pension or retirement income | | | |
| Interest,dividends,royalties,income from rental Properties, estates, trusts. Alimony, child support Or assistance from outside the household | | | |
| Total Income | | | |

| If Unemployed initial here | **** | If No Income initial here | **** |
|---|---|---|---|

I certify that all information on this application is a true statement of income and family size. I understand that if I qualify for the sliding fee discount, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal from care.

I agree to report any changes within 30 days. Initial determinations are ONLY valid for 30 days from the acceptance date without supporting documentation for income. To extend this agreement I must provide proof of income.

Signature :_____ Date: _____

OFFICE USE ONLY

Patient Name:_____

Approved Discount:_____

Approved by: _____

Date approved: _____

EXPIRES (30 DAYS): _____

4/1/2025