

Pediatric Wellness of Northern New York

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SLIDING FEE DISCOUNT PROGRAM APPLICATION

It is the policy of Pediatric Wellness of Northern New York to provide essential services regardless of the patient's ability to pay. Pediatric Wellness of Northern New York offers discounts based on family size and annual income.

Please complete the following information and return it 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 purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

Patient Name

Patient DOB

Address

City, State, Zip

Phone

PLEASE LIST ALL HOUSEHOLD MEMBERBS, INCLDING SELF		
NAME	DATE OF BIRTH	RELATION

PLEASE LIST ALL SOURSES OF INCOME (Annual Income)			
SOURCE	SELF (PATIENT)	OTHER	TOTAL
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensations, workers compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
TOTAL INCOME			

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

Print Name

Relationship to Patient

Signature

Date

OFFICE USE ONLY

Patient name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Check List	Yes	No
Identification/Address: Driver's License, utility bill, employment identification, or other		
Income: Prior year tax return, three most recent paystubs, or other		