Patient Registration Form

This form is for new patients or patients that have not been seen by a provider in more than two years. You will need to complete this form in its entirety before your first appointment.

SLIDING FEE DISCOUNT PROGRAM DECLARATION

INCOME DECLARATION

I, [Your Name] _____, declare my annual income as $_____. By making this declaration, I understand that I may qualify for a one-month period of eligibility for the Heart of Florida Health Centers Inc. sliding fee scale program based on the income stated above. After this initial one-month period, I must provide documentation of income (such as pay stubs, W-2s, Medicaid Denial, food stamps documentation, etc.) to maintain my eligibility status. Failure to provide such documentation will result in being designated as Full Fee status. I acknowledge that I can only self-declare my income once per year at Heart of Florida Health Centers Inc.

PARTICIPATION IN THE SLIDING FEE DISCOUNT PROGRAM

- ☐ Option A: I am providing my income details but decline to apply for the Heart of Florida Health Centers Inc. Medical, Dental, Behavioral Health, and Pharmacy Sliding Fee Scale program. By declining, I accept financial responsibility for the entire bill, including any fees not covered by my insurance plan, and agree to pay any balance in full.

- ☐ Option B: I am providing my income details and wish to apply for the Heart of Florida Health Centers Inc. Medical, Dental, Behavioral Health, and Pharmacy Sliding Fee Scale program. (You will be required to complete a Sliding Scale Application and provide proof of income, residency, and photo identification.)

- ☐ Option C: I decline to provide income details and therefore decline to apply for the Heart of Florida Health Centers Inc. Medical, Dental, Behavioral Health, and Pharmacy Sliding Fee Scale program. By declining, I accept financial responsibility for the entire bill, including any fees not covered by my insurance plan, and agree to pay any balance in full.

By signing below, I agree to the above requirements and expectations.

Print Name: _____ Relationship to Patient: Date:

Signature: _____ ☐ Self ☐ Legal Custodian ___/___/_____

☐ Natural Guardian (Parent) ☐ Legal Guardian

Annual Update Needed

Patient Name: _____

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SLIDING FEE DISCOUNT PROGRAM APPLICATION

At Heart of Florida Health Center, we offer essential services to everyone, regardless of their ability to pay. Discounts are available based on household income and size. A "Family" includes all individuals living together who are related by blood, marriage, or law, including both adults and minor children. Relatives over 18 who are not full-time students cannot be considered dependents for this application process. Please answer the following questions to see if you or your family members qualify for our sliding fee scale program.

The full completion of this form is REQUIRED if you selected Option B on the previous page SLIDING FEE DISCOUNT PROGRAM ATTESTATION.

Information Required		
FAMILY SIZE Total dependents include any immediate family members living in the home (i.e., mother/father/children) and any person who lives in the home and mutually contributes to household expenses.	_____ # of adults _____ # of children	
INCOME Include income from all dependents in the household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.	$ _____	☐ Weekly (52 wks.) ☐ Bi-Monthly (24 wks.) ☐ Monthly (12 months) ☐ Yearly/Annual (1 year)

Please check all supporting documentation you will be providing with this application

PROOF OF INCOME:	GOVERNMENT-ISSUED IDENTIFICATION:
☐ Wages and Federal Tax Statement (e.g., W-2) ☐ Paystub ☐ Determination or Benefits Verification Letter ☐ Self-employment ledger documentation ☐ Employer Statement (signed by the employer with company logo) ☐ Other: _____ ☐ No income was presented. ○ Self-Declaration Form must be completed. ○ Letter of Support needed if 0 household income.	☐ Driver's License ☐ Passport ☐ US Immigration Form ☐ Other: _____

Print Name: _____ Relationship to Patient: Date:

Signature: _____ ☐ Self ☐ Natural Guardian (Parent) ☐ Legal Custodian ☐ Legal Guardian ___/___/_____

Annual Update Needed

Patient Name: _____