PEDIATRIC ASSOCIATES

Financial Assistance Application

Patient Name: _____Date of Birth:_____

Parent Name_____Date of Birth_____
Last First MI

Parent Name_____ Date of Birth_____
Last First MI

Address_____
Number and Street, Apt# City State Zip

Telephone (____)_____Occupation:_____Employer_____

Employer Address_____ Employer Tel #_____

Email Address: _____

In the event you had experience catastrophic events please check here. ☐

Income- List combined income for you, spouse and all other household members

TYPE OF INCOME	**CHECK LAST 3 MONTHS**	**TOTAL**
Wages		
Self-Employment Earnings		
Public Assistance		
Social Security		
Unemployment Workers' Compensation		
Alimony		
Child Support		
Pensions		
Income From Dividends		

Pediatric Associates request you submit documentation to substantiate the income you entered above. Example include pay stub, letter from employer if applicable, form 1040, etc.

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FAMILY SIZE- Family members living in the same household
Note: Please attach additional sheet if space is needed

NAME	AGE	RELATIONSHIP

This application is submitted to Pediatric Associates Billing Department within a calendar year. Once you have submitted a completed application and supporting documentation at the address below, you may disregard any bills until the Billing Department has rendered a written decision on your application

To submit this Financial Assistance application please read the following statement and sign were indicated below

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I hereby request Pediatric Associates to make a written determination of my eligibility for Financial Assistance. I understand the information which is submitted concerning my annual income and Family size is subject to verification by Pediatric Associates. I also understand if the information which I submitted is determined to be false, such determination will result in denial of hardship and I will be liable for services provided at Pediatric Associates facilities. I affirm the information above is true and correct to the best of my knowledge further; I hereby give permission to Pediatric Associates to verify any information pertinent to this application.

DATE: _____

SIGNATURE OF APPLICANT:
_____

ACCOUNT NUMBER: _____

COMPLETED APPLICATION TO BE SENT TO:

Pediatric Associates
8201 Peters Road, Suite 4100
Plantation, FL 33324
OR FAX TO (954) 967-8060 Attn: Billing Department

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DO NOT FILL OUT FORM AFTER LINE, BILLING OFFICE ONLY!

Completed By Billing Department:

Representative:_____

Representative Signature:_____

Office Location:_____

Date of Service:_____

Total Balance Of visit:_____

FA Approval Amount:_____

Total Amount owed on Bill:_____

Reach patient by: __mail __email __Phone