



SLIDING FEE DISCOUNT PROGRAM FORM

We will care for you even if you cannot pay. You may be eligible for a discount based on your income and family size. Discounts are available even if you have insurance.

Patient Name:	Date of Birth:	Responsible Party (if different):

1. Family Size*: Including yourself, how many people are in your family? _____

2. Total Family Income: Enter the total income for everyone included in your family size above.

Amount: \$ _____ Frequency: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

3. Select ONE option:

☐ I choose to participate in the Thundermist Sliding Fee Discount Program.

☐ I do not want to participate in the Thundermist Sliding Fee Discount Program.

I understand that my eligibility for the Thundermist Sliding Fee Discount Program is based on family size and income. I agree to notify Thundermist if my family size or income changes, which may affect my eligibility or discount. I certify that the information provided above is correct to the best of my knowledge.

Patient/Responsible Party Signature: _____ Date: _____

***Family Size Definition:** Include yourself and other people related by birth, marriage, or adoption who live together. Family also includes unrelated people who live in the same household and are supported by or supporting a member of the family. Foster children are not included in family size.

OFFICE USE ONLY

Advanced Dental Service?	Verification Completed By/Date
☐ Yes ☐ No	