THE CENTER FOR THERAPEUTIC SERVICES AND PSYCHODIAGNOSTICS HAS ADOPTED THE FOLLOWING POLICIES FOR CHARGES FOR HEALTH CARE SERVICES

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at a reduced charge to persons unable to pay for services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges. We will not discriminate against any person receiving health services because of their inability to pay for services.

CENTER FOR THERAPEUTIC SERVICES AND PSYCHODIAGNOSTICS

APPLICATION FOR REDUCED FEE

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted. Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the minimal rate.

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET	CITY	STATE	ZIP	PHONE #
HEALTH INSURANCE PLAN	POLICY #	Annual Income Amount: $_____,		SOCIAL SECURITY NUMBER: _____-_____-_____

Number of Individuals in the Household

RELATIONSHIP	NAME	DATE OF BIRTH	INCOME
Self			
Spouse/Partner			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			

SOURCE OF INCOME	SELF	SPOUSE	OTHER	TOTAL
Alimony, child support, military family allotments				
Income from employment, business self-employment, and dependents				
Rent, interest, dividend, pension, social security, annuity, veteran's benefits				
TOTAL INCOME				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income will be required before a discount is approved.

Name (Printed) _____ Date: _____

Signature _____

VERIFICATION CHECKLIST (attach copies)

FORM	YES	NO
Identification/Address: Driver's license, birth certification, social security card, other		
Income: tax returns, three most recent pay stubs, or other		
Copy of Insurance Card/TYPE:		

FOR OFFICE USE ONLY:

CLIENT NAME: _____ **APPROVED BY:** _____ **DATE:** _____	**6 MONTH DISCOUNT AMOUNT:** **$**_____