VEEMAH Integrated Wellness and Consulting Services, LLC
7070 Brooklyn Boulevard, Brooklyn Center, MN, 55429

INFO@VEEMAHCONSULTING.COM
OFFICE: (763) 202-4767
FAX: (763) 355-5718
WWW.VEEMAH.COM

SLIDING FEE APPLICATION

PATIENT INFORMATION

Date: _____/_____/ _____

Please help us determine if you are eligible for discounted fees for services not covered by insurance or if you have difficulties paying for your deductible. The information you provide will be kept confidential and only accessed by the administrator responsible for billing.

FIRST AND LAST NAME:_____

DATE OF BIRTH:_____ LEGAL GENDER:_____

PHONE NUMBER:_____

ADDRESS:_____

1) MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOW(ER)

2) WHAT IS THE NUMBER OF PEOPLE LIVING IN YOUR HOME?:_____

3) WHAT IS YOUR **MONTHLY** HOUSEHOLD INCOME (COMBINED FOR ALL EARNERS)?:_____

4) BASED ON YOUR INCOME BRACKET AND HOUSEHOLD SIZE, YOU AGREE TO PAY _____ PER MONTH FOR SERVICES?

PLEASE REVIEW AND SIGN BELOW

I hereby affirm that to the best of my knowledge that the information provided on this application is true and correct. I understand that any misleading or falsified information and/or omissions may disqualify from participating in the sliding fee scale program. I further agree to inform VEEMAH of any significant changes in my income.

I agree to make a payment of $_____: (Select one) ☐ Weekly ☐ Bimonthly ☐ Monthly

CLIENT GUARDIAN NAME (**IF APPLICABLE**): _____
(WRITE FULL NAME IN PRINT ONLY)

CLIENT OR GUARDIAN SIGNATURE: _____ Date: _____
(RESPONSIBLE PARTY MUST SIGN)

Once the form is completed, it can be sent by fax to 763-355-5718, by secure email to INFO@VEEMAHCONSULTING.COM, or dropped off at the clinic. If you prefer to drop off your application in person, please call the office in advance at 763-202-4767 to make arrangements.

OFFICE USE ONLY:

Approved: _____ Date: _____
(VEEMAH STAFF NAME)