VEEMAH Integrated Wellness and Consulting Services, LLC
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HUMILITY & INNER STRENGTH
VEEMAH

SLIDING FEE APPLICATION

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.

PATIENT INFORMATION

Last Name:			First Name:		
Date of Birth:		Gender: ☐ F ☐ M			
Phone Number:					
Address:					
Marital Status:	Single ☐	Married ☐	Divorced ☐	Separated ☐	Widow(er) ☐
Number of people living in your home:					
What is your monthly household income; single or combined? _____					
Based on your income bracket and household size, you agree to pay, _____					

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

Name: _____
CLIENT/PARENT/GUARDIAN

Signed: _____ Date: _____

Approved: _____ Date: _____
VEEMAH STAFF