Physician Office Participation Agreement

Name_______________________________________

Address_____________________________________

City_________________________ State_____ Zip Code________

E-mail(will not be given out
publicly)_____________________________________

Telephone (   ) ____________________________________

Fax____

I submit my request to be included in ZIAD's program to help the uninsured. I understand that ZIAD will only be referring the patient to my office to participate in a sliding scale program. It is not an insurance program.All forms are on the web site for my use and I will send back encounters by fax to 810-458-4187 on all patients that I see for statistical purposes.

Our office will have the patient complete a ZIAD registration form, and an encounter form along with your customary documents and fax back those forms to ZIAD. I agree to charge the patient the normal charge of the office and any other items provided less the percentage discounted based on the sliding income scale.

A physician may opt out for any period of time or resign from the program at any time. Thank you for helping the uninsured poor.

Physicians Signature_____________________________________
Date____________