BORINQUEN MEDICAL CENTERS

Patient Name: ____________________________ MR #: __________________

Sliding Scale Discount Determination

1. A patient is responsible for estimated payment at the time of service. The patient will be billed later for additional costs such as shots, lab tests and x-rays.

2. If a patient wishes to apply for (or continue with) the Sliding Fee program, he or she must show proof of income. If not, and individual cannot participate (or continue to participate) in the program. That means the patient will be responsible for the total bill.

3. In order to prove family income, new patients must provide information before they will be qualified for the Sliding Fee Program. Current patients must bring their information at their next visit. The information required for both new and current patients is as follows:

   A. Federal Tax Return (most recent)
   B. Pay stubs (last two for all working members of the family) and other income for last month.
   C. Rent receipt (most recent)
   D. Utility receipt (most recent)
   E. Telephone bill (most recent)

4. I understand that I am responsible for all charges not covered by a third party payer and that Borinquen Medical Centers may refuse future non-acute medical services (for reasons other than inability to pay) and that Borinquen Medical Centers may engage a collection agency to collect from me services at Borinquen Medical Centers based on the following criteria:

- ☐ Certificate low income status — Family Size: _____________________
- ☐ (Complete Income Assessment) — Annual Income: $ _______________
- ☐ Medicare, Medicaid, Private Insurance Card
  Date issued: _________________________ Expires: ________________________
- ☐ Food Stamp Recipient, USDA Identification:
- ☐ Special Circumstances (Specify): ____

Sliding Fee based on income and family size (circle one): A B C D E

_______________________________________ _________________________

Patient's Signature Date

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Witness (Assessor)