BORINQUEN MEDICAL CENTERS

TO: _____ DATE: _____
(Patient's Name)

Self-Declaration Form:

We appreciate the opportunity to provide you with health services. You will be asked to fill out our patient information form and medical history form.

All charges and fees are based on sliding fee scale. Services rendered are expected to be paid for the date of services. The sliding fee scale is based on total household size and income. In order to qualify for the sliding fee scale, you must provide one of the following sources of information:

1. A current pay stub
2. A copy of your disability check
3. A copy of your SSI check
4. A current unemployment check
5. A current unemployment statements
6. Child support check
7. Court order settlements
8. Income Tax statement
9. Any other written verifiable income statements

A nominal charge for services rendered is $25.00 for the office visit and $10.00 to $25.00 for any outside lab work necessary. There are also nominal charges starting $10.00 for other procedures. Sources of acceptable payments are cash, credit card, Medicare, Medicaid, and HMO/ private insurances.

Self- Declaration of required information:

My current total household income is $ _____.

My current total number of household members are _____.

I have read the following information and understand the qualification and documentation necessary to apply for the fee scale. I further understand that if I do not provide the necessary information during my next visit I will be required to pay 100% of charges for all services received.

Signature _____ Date: _____

Staff Signature: _____ Date: _____