HEMANT PATEL MD PC

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Hemant Patel MD PC has the policy to serve all the patients regardless of their ability to pay. The eligibility is decided and discounts are made available to the patients based on their family size and annual income. Please complete the following application and submit it to us to determine your eligibility for the discount and be considered for the Sliding Fee Scale policy.

Please note that this discount and the fee scale will only be applicable to the services provided at this clinic, and not to any other services rendered from outside including laboratory testing, and any other such service.

The following Sliding Fee Scale application is to be completed once every year or if there is a significant change in the income.

Sliding Fee Scale: Application Form

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( )		Cell Phone #: ( ) -		
Date of Birth: / /	Do you have insurance? (circle one) Yes No			
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size	
Name	**Date of Birth**
	/ /
	/ /
	/ /
	/ /
	/ /

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

Sliding Fee Scale:

A - Nominal Fee

B – 80% Discount

C – 60% Discount

D – 40% Discount

E – 20% Discount

F – 0%Discount

I certify that the information provided on this application is true to the best of my knowledge. I agree that any falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and/or imprisonment. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____