BILLING INFORMATION AND SLIDING FEE SCALE ELIGIBILITY
ANNUAL INCOME DECLARATION

Quality of care is a patient's first priority when seeking medical attention. This is our priority too. You will also find that our fees are comparable to other medical offices in the area and are significantly lower than those charged by hospital emergency rooms. If you qualify for a sliding fee scale, it will apply to a variety of services.

We accept Medicare, Medi-Cal, Dental-Cal and many public and private insurance plans. You may qualify for a sliding scale discount. We also have special discount programs for eligible patients in family planning, prenatal care, well-child care, immunizations, school health physicals and mental health. Depending on eligibility and billing requirements, payment is expected at the time services are rendered; all co-payments must be paid before services are rendered. Any fees not covered by a third party payer you will be responsible for any balance.

If you need to cancel a visit, you must call 24 hours in advance. Failure to cancel an appointment will result in a **"NO SHOW" $20.00 fee.**

Please bring an adult to supervise your children if you are planning to bring them to your appointment.

If you have Medicare or private insurance that covers doctor's visits, you should always bring your insurance card with you. If your insurance does not cover services provided by the clinic, you may be eligible for a discount.

If you have Medi-Cal, you should always bring your plastic Benefit Identification Card (BIC) to your appointments. In order for us to verify eligibility, we must know the number listed on your Benefit Identification Card.

Should you have any billing questions, you must come in person and speak with the Patient Accounts Representative within 30 days of your bill statement or you may risk going to collections.

I have read the statement and I agree to accept financial responsibility for services rendered.

Signature:_____Date:_____

In order to qualify for our Sliding Scale Discount Please complete the following:

SELF DECLARATION: I, _____, am not able to produce for San Benito Health Foundation the requested income documentation, but attest to fact that the information I have provided is true to the best of my knowledge.

Signature:_____ Date:_____

Household Income: $_____wk/Bi-wk/mo/Yr Family Size:_____

Verification of Information: 2011/2012 Federal/State Income Tax
Unemployment/Disability
W-2 Forms/Workmen's Comp.
Paycheck Stubs

Employee Witness:_____Date:_____