ReGenesis Health Care

SELF-DECLARATION
Eligibility for Federal Poverty Sliding Fee Adjustment

PATIENT'S NAME:_____
DATE OF BIRTH:_____
SOCIAL SECURITY NUMBER:_____

This is to certify that I, _____, am the head of the household/and or the responsible party for the above named individual. This is to declare that I am/am not receiving income and failed to bring proof for the office visit today.

Non working Individuals
I further declare that no other family member is receiving income that would pay for services. I understand that when I or any other family member begin to receive any type of benefit, I must report it to your agency. I understand that if I do not bring the required proof to the next office visit, I will be billed at 100% and will not receive any discount or I can reschedule the appointment when the information is available.

Working Individuals
I further declare that the amount of income listed below is an estimate that will be used for a one time office visit. Proof of income will have to be brought back to the office upon next scheduled appointment. I understand that if I do not bring proof of income to the next office visit that I will be billed at 100% and will not receive any discount or I can reschedule the appointment when the information is available.

CURRENT ESTIMATED INCOME:_____

THIS SELF DECLARATION IS ONLY GOOD FOR TODAYS VISIT ONLY

_____ Date:_____
Patient Signature

_____ Date:_____
Signature of Office Personnel/Witness