Automatic Sliding Scale
FEE DETERMINATION FORM

Patient Name: ____

I am willing to disclose my financial situation and thereby realize my fee schedule will be based on the following two facts:

Family Size _____________ that I directly support myself (or my spouse) or jointly.

Estimate total family income (both husband and wife)

Yearly _________ Monthly_________ Weekly_________

____
Patient Signature

DO NOT WRITE BELOW THIS LINE CLINIC STAFF ONLY

Guarantor's Name ______________________________

Patient's Name ______________________________

Assigned financial class BC PR
(Circle One)

Date ________

____
Clinic Representative