



GLENN'S FERRY  
**PHYSICAL  
 THERAPY**

## Sliding Scale

Instructions: Find the row that matches the number of persons in your household. Select from that row the dollar amount in which your household income is ≤ the amount listed.

Persons in Household	Federal Poverty Guidelines (Annual)*				
	≤100%	≤138%	≤250%	≤400%	Greater
1	\$12,490	\$17,236	\$31,225	\$49,960	>\$49,960
2	\$16,910	\$23,336	\$42,275	\$67,640	>\$67,640
3	\$21,330	\$29,435	\$53,325	\$85,320	>\$85,320
4	\$25,750	\$35,535	\$64,375	\$103,000	>\$103,000
5	\$30,170	\$41,635	\$75,425	\$120,680	>\$120,680
6	\$34,590	\$47,734	\$86,475	\$138,360	>\$138,360
7	\$39,010	\$53,834	\$97,525	\$156,040	>\$156,040
8	\$43,430	\$59,933	\$108,575	\$173,520	>\$173,520
<b>Cash Pay Rate</b>	\$20.00	\$40.00	\$60.00	\$80.00	\$100.00

Add \$4,320 for each person over 8

Patient Name: \_\_\_\_\_

Cash pay rate is \_\_\_\_\_ dollars per visit.

**► IF PATIENT IS UNDER THE AGE OF 18 ◀**

For patients under 18 years of age, the parent, relative, or person responsible for the patient is responsible for any payments due at the time of service.

I \_\_\_\_\_ (responsible party if not the patient) understand that I am responsible for all charges incurred for physical therapy treatment for the patient.

**► RESPONSIBLE PARTY SIGNATURE STATEMENT ◀**

By signing below, I declare that all the information I have provided on this form is true and accurate to the best of my knowledge. As the responsible party, I agree to pay the rate listed above for each physical therapy visit.

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Proof of Income

Please bring in one or more of the following documents to verify your entire household income.

## Types of Documents That Can Verify Income

Type	Best For
<b>Pay Stubs</b>	Primary proof of income for any W-2 employees
<b>Tax Returns</b>	Primary proof of income for self-employed small business owners
<b>Bank Statements</b>	Secondary documents used to corroborate pay stubs, tax returns, or Social Security benefits
<b>Letter from Employer</b>	Secondary documentation used with W-2 employee pay stubs
<b>Profit and Loss Statement</b>	Secondary proof of income for self-employed patients
<b>Social Security Benefits Statement</b>	Primary proof of income for retirees
<b>Court Ordered Agreement</b>	Primary proof of income for those collecting alimony or similar payments

### ► FOR OFFICE USE ONLY ◀

Circle and initial the documents provided by the patient as proof of income. Scan in documents and sign below.

Person reviewing this information \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_