

SAN ANTONIO METRO HEALTH DISTRICT
Please complete this form and return it to the Registration Clerk.

Patient Financial Information

Family Size (Number of People, including yourself) <input type="checkbox"/> 1-Me <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> _____	For Payment today: <input type="checkbox"/> No-Insurance <input type="checkbox"/> I have Insurance
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No Insurance - For Payment Out-of-Pocket
SAMHD utilizes the Sliding Scale Fee Payments for non-insured patients. If you do not have insurance, your bill will be a percentage calculation based on your household income and household size. Please complete the section below for your payment discount off of your visit bill.

Family Incomes (Earnings of any of the people that live with you, including teenagers. Earning is any incoming money, including government assistance, child support payments, etc.)

#1)	Family Members First Name	Income Amount \$	Period of Earnings <input type="checkbox"/> Annual <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
	Is this Employment Income? <input type="checkbox"/> No <input type="checkbox"/> Yes	Who is the Employer?	
#2)	Family Members First Name	Income Amount \$	Period of Earnings <input type="checkbox"/> Annual <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
	Is this Employment Income? <input type="checkbox"/> No <input type="checkbox"/> Yes	Who is the Employer?	
#3)	Family Members First Name	Income Amount \$	Period of Earnings <input type="checkbox"/> Annual <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
	Is this Employment Income? <input type="checkbox"/> No <input type="checkbox"/> Yes	Who is the Employer?	
#4)	Family Members First Name	Income Amount \$	Period of Earnings <input type="checkbox"/> Annual <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
	Is this Employment Income? <input type="checkbox"/> No <input type="checkbox"/> Yes	Who is the Employer?	

I have no household income, and I am currently unemployed _____ **Initial Here**

Insurance Information

Name of Insurance Company/Insurance Plan

Is your Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance	Insurance Policy #:	Copay Amount (if applicable) \$
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Effective Date (Term Beginning) / /	Effective Through (Term End) / /	Group Number (if applicable)
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