

**John M. Pramenko, MD, P.C.**



*Your Personal Care Family Doctor*

2310 Nott Street East

Niskayuna, NY 12309

518-381-4133

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**Application for Discounted Fees**

Fill out one column:

	Monthly	or	Yearly
Family income (wages)	_____		_____
Other income (disability, child support, etc.)	_____		_____

Number of family members in your household \_\_\_\_\_

Please provide a copy of your most recent paycheck, W2, or income tax form.

By signing below I agree to inform Dr. Pramenko of any changes in my income and submit a revised application accordingly.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print name)

**Discount levels**

Number in Family	Yearly Income		
1	<\$10,000	\$10,000-30,000	\$30,000-60,000
2	<\$15,000	\$15,000-35,000	\$35,000-65,000
3	<\$20,000	\$20,000-40,000	\$40,000-70,000
4	<\$25,000	\$25,000-45,000	\$45,000-75,000
5	<\$30,000	\$30,000-50,000	\$50,000-80,000
Discount =	75%	50%	25%

(add \$5000 to the income columns to calculate charges for each additional family member beyond 5)