PATIENT FINANCIAL SUPPORT APPLICATION

Today's Date:	Referring Provider:	
PATIENT INFORMATION		
Last Name:	First Name:	Middle:
Address:		
City:	State:	Zip code:
Phone:		DOB:
INSURANCE INFORMATION		
Does the patient have medical coverage (Circle one)? Yes No If "Yes" please list responsible party information: (Please include a copy of insurance card.)		
Insurance Carrier Name:		Phone:
Address of Insurance Carrier:		
Policyholder Name and ID #:		
FINANCIAL INFORMATION		
(ALL VALUES SHOULD REFLECT YEARLY AMOUNTS FOR ENTIRE HOUSEHOLD)		
Total Gross Yearly Income: $_____ (include pay stub, W-2, unemployment or disability statement, or other verification of income) Household Size: _____ (Number of people who contribute to or are dependent on your household income)		
Your application may be subject to audit or request for additional documentation.		
I hereby swear under penalty of perjury under the laws of the United States that the above information is true and correct. I authorize verification of the above information for the sole purpose of assessing financial need. I understand that if I do not qualify, I will be notified and billed for any balance due. I agree to provide notice if my financial condition changes.		
Patient Name (Print):		
Patient Signature:		**Date:**
FOR OFFICE USE ONLY		
Process Date:	Total Owed:	
Discount Approved:		
Processor Last Name:		
Denial Reason:		
Approver Name (Print):		
Approver Signature:		**Date:**