Financial Hardship Form

Name of Patient:________________________________Date of service:___________

Amount due:____

I am asking this practice for the following concession:

___ Waiver of my copayment
___ Waiver of my deductible
___ Discount on my medical charges
___ Payment Plan to pay my patient-owed balance
___ Other
(explain)____
____
____

Reason for my financial hardship (check all that apply)

___ Lost job
___ House foreclosure
___ Temporary job lay off
___ Catastrophic family illness
___ Lost health insurance
___ Other (explain)
____
____
____
Arrangements
made:____
____
____

This arrangement will expire on ____

____
Signature of Patient Date:____________________

____________________________ Date:____________________
Signature of Witness