FINANCIAL HARDSHIP PATIENT ATTESTATION AND APPLICATION FORM

Patient Name:		
Address :		
City:	**State:**	**Zip code:**
Phone Number:	**DOB:**	

I hereby declare that I cannot afford to pay the full amount of patient financial responsibility due to financial hardship.

I therefore request a reduction or waiver of my charges.

I understand that the Practice Group may waive collection of amounts in my case due to my financial hardship.

I authorize the Practice Group to verify the above information for the sole purpose of assessing my financial need and ability to pay.

I understand completion of this attestation and the attached application does not guarantee I will be relieved of financial responsibility.

I agree to notify Practice Group if my financial condition changes or improves.

I hereby swear under penalty of perjury under the laws of the United States that the above information and the information in the attached application is true and correct, and that it would impose a significant financial hardship on me if I were required to pay the full amount of patient financial responsibility.

Patient Name (Print):_____

Patient Signature:_____ Date:_____

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