Waiver of Payment
Due to Financial Hardship

For those patients who are unable to meet the financial obligation, but still in need of services, the following information is required. Please print the answers to all questions in the spaces provided.

Patient Name: ___________________________________ Account #__________________

Address ____ Phone # __________________

City, ST, Zip ____ Date of Birth _______________

Responsible Party:______________________________Employer:______________________________

Primary Insurance Coverage

Insurance Name ____________________________ Subscriber Name ____________________

Claim Address ____________________________ ID # ______________________________

City, ST, Zip ____________________________ Group #___________________________

Secondary Insurance Coverage

Insurance Name ____________________________ Subscriber Name ____________________

Claim Address ____________________________ ID # ______________________________

City, ST, Zip ____________________________ Group #___________________________

I am unable to pay my personal portion of medical charges due to financial hardship. (please explain)

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I understand that my medical provider is waiving the collection of the deductible and/or co-payment (___%) in my case, due to my financial hardship situation. I also understand that my physician is required to and may begin collecting these charges when my financial situation improves. I must report any change in my situation to my provider.

_____________	_____________________________	________________________
Date	Signature of Patient or Financially Responsible Party	Signature of Provider

Subsequent Encounters (Financial status should be confirmed by the provider's agent quarterly if service is on-going)

Date	Situation Improved/Same	Patient or FRP Initials	Provider Initials
____________	________________	______________	__________
____________	________________	______________	__________
____________	________________	______________	__________

Complete a new form after four encounters.