Financial Hardship Agreement

I, _____, understand that I am personally financially responsible for any and all costs for my medical expenses that incur either because my insurance only covers a portion of the cost or because I have no insurance at the time of service. However, at this time I have financial difficulty which is making hard for me to pay for part or all of the expenses I am responsible for because of the following:

Low or fixed income – Annual Household Income $_____ with _____ total household members

____ Without any or applicable insurance for treatment at this clinic

____ With applicable insurance but not full coverage for this treatment

I request under this Financial Hardship Agreement for the following discount assistance based on my annual household income and total family members. I would not be able to afford the cost of living if I was forced to pay in full for this treatment. I request this discount for the time period of from _____ to _____.

Patient's Signature _____ Date _____

Patient will receive the following discount based on their annual income levels.

____ Minimum co-pay per office visit of _____

____ Discounted rate of _____% of the total charges

Provider's Signature _____ Date _____