WAIVER OF PAYMENT DUE TO ECONOMIC HARDSHIP

DATE: ________________ ACCT: ________________

PATIENT NAME: ____

ADDRESS: ____

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PHONE NUMBER: ______________________________

NAME OF REFERRING PHYSICIAN: ______________________________

MARITAL STATUS: ____________________ EMPLOYMENT STATUS: ____________

APPLIED FOR MEDICAID: YES NO IF NO, WHY ______________________________

OF MEMBERS IN HOUSEHOLD: __________ **ANNUAL INCOME**: ________________

Are there any family members that could assist you? ______________________

MONTHLY INCOME:

MONTHLY EARNING: ______________________

SOCIAL SECURITY BENEFITS: ______________________

PENSION/RETIREMENT BENEFITS: ______________________

GOVERNMENT ASSISTANCE: ______________________

SPOUSAL INCOME: ______________________

OTHER SUPPLEMENTAL INCOME: ______________________

TOTAL INCOME: ________________

MONTHLY EXPENSES:

RENT/MORTGAGE: ______________________

FOOD: ______________________

UTILITIES (ELEC, WATER, GAS, CABLE, CELL): ______________________

MAINT. (AUTO INS, RENTER INS, LIFE INS): ______________________

LOANS (AUTO, CC, BANK): ______________________

MEDICAL EXPENSES: ______________________

OTHER (GAS, DAYCARE): ______________________

TOTAL EXPENSES ________________

ADDITIONAL COMMENTS: ____

I certify that the above information is true and that any false information given by me may result in my status becoming non-eligible for hardship, therefore making me responsible for any amounts due to Careplex Orthopaedic Ambulatory Surgery Center.

PATIENT SIGNATURE: ______________________________

FOR OFFICE USE ONLY

FINANCIAL COUNSELOR: ______________________

DATE: ________________ APPROVED? YES NO

COMMENTS: ____

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