

*(Should be Typed on Your Letterhead)*

**WAIVER OF PAYMENT  
DUE TO FINANCIAL HARDSHIP**

*(Print or Type)*

PATIENT NAME \_\_\_\_\_  
I.D. NUMBER \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

For the reasons checked below, I am unable to pay the unreimbursed medical charges due to economic hardship. In addition, I do not have a guardian or other responsible party who can assist me with these expenses.

Please explain: *(Select all that apply)*:

- Unemployed     No insurance     Dependent on family for support
- Low or fixed income     Student     High medical expenses     Bankrupt
- Not covered by state or local welfare program
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*SUPPLEMENTAL INSURANCE (If Applicable)*

COMPANY NAME \_\_\_\_\_ I.D.# \_\_\_\_\_  
PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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I waive the collection of unreimbursed medical charges on the above mentioned patient/family.

AUTHORIZED SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_