(Should be Typed on Your Letterhead)

FINANCIAL HARDSHIP WAIVER

(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 ❒ Bankrupt ❒ Dependent on family for support

❒ Low or fixed income ❒ Student ❒ High medical expenses

❒ Not covered by state or local welfare program

❒ Other: ____

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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_____________________