

**APPLICATION FOR REDUCTION OF BILL OR EXTENDED PAYMENT PLAN**

Patient Name: \_\_\_\_\_ Guarantor Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Health Insurance: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Gross Monthly Income:

Self: \_\_\_\_\_

Spouse: \_\_\_\_\_

Other: \_\_\_\_\_

Total: \_\_\_\_\_

Monthly Household Expenses:

Mortgage/Rent: \_\_\_\_\_

Insurance: \_\_\_\_\_

Utilities: \_\_\_\_\_

Car Payment: \_\_\_\_\_

Food: \_\_\_\_\_

Medical: \_\_\_\_\_

Total: \_\_\_\_\_

Number of Dependents in Household (Including self): \_\_\_\_\_

Medical Expenses:

Providers:

Amount Due:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient or Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Final approval will require a copy of your most recent income tax form accompanied by supporting W-2/ 1099/ SSA 1099 statements. If you do not file a tax return or if you have had significant financial changes, please explain on the reverse side of this form. Please return this form and all attachments to the attention of the Practice Manager at the address listed on this form.

We appreciate the opportunity to work with you to resolve this outstanding balance.