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.