Hollingshead Eye Center, P.C.℠

Name: _____

Address: _____

Phone: _____

Account Number: _____

Financial Assistance Application

Sometimes proper medical care may seem to be out of reach due to financial difficulties or special circumstances. Our primary concern is the health of your eyes. We want you to receive the appropriate doctor recommended eye care you need. Please, in a few words describe your current circumstances and how we can help make your eye care affordable.

_____

_____

Have you already scheduled an appointment? Yes ___ No ___

What problem will we be treating you for? _____

Please check all that apply:

[ ] Bankruptcy [ ] Unemployed [ ] No Medical Insurance

[ ] Fixed/Low Income [ ] No Income [ ] Other _____

Budget:

Net Monthly Income for Household	$_____
# of People in household _____	
Rent/Mortgage (own ___ rent ____)	$_____
Utilities	$_____
Transportation Expenses (car payment, gas, insurance)	$_____
Medical Expenses	$_____
Loan/Credit Card Payments	$_____
Personal Expenses (groceries, etc.)	$_____
NET =Total Income less Expenses	$_____

Please return this form to us with a **copy of your most recent Federal tax return** and allow one week for a decision which is based on Federal poverty guidelines.

I attest that the above information is true to the best of my knowledge. If I request insurance to be billed after the surgery is performed, the charges will revert to undiscounted, full fee and may cause my payment responsibility to change.

_____ _____ _____

Patient Signature Approval Signature Date

**This application will be presented to our financial committee and you will be notified of their decision and your final cost. THIS APPLICATION IS GOOD FOR 6 MONTHS

Level of Hardship approved _____

Effective Date _____

Revised 10/17/2017 sf