FINANCIAL WAIVER

Date

Patient Name

Social Security _____ - _____ - _____

Number of Family Members: _____

Source of Income: ☐ Employed ☐ Unemployed ☐ Social Security ☐ Other

Please check one of the following for applicant's yearly income:

☐ Less than $,7000 ☐ Less than $10,000 ☐ Less than $15,000 ☐ More than $15,000

Any additional income: _____

I hereby agree to the terms requested by the Doctor's office to make a determination to qualify me for the balance of services to be waived. I understand that if the information, which I submit is determined to be false, I will be responsible for payment of all services rendered. I also understand that the information provided is considered confidential and that the request for such information is a requirement to comply with Medicare Part B laws and regulations.

I further attest that Medicare is my only source of insurance and I have no supplemental insurance.

_____ _____

Signature Date

_____

Witness