Financial Assistance Application: Patient Agreement Signature Page

This document is the Patient Agreement to support your request for Financial Assistance. Please add your signature below, upload this page online in MyChart, and submit your application. If you do not have the ability to upload into MyChart, we will mail the Patient Agreement to you and provide a return mail address.

Your application will be considered incomplete without this signed signature page.

PATIENT AGREEMENT

I understand that the organization I selected above may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the information I have provided in the online application is correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Applicant **Date**

_____

Name of Hospital or Clinic where services were provided

ADDITIONAL INFORMATION

You may use the below blank section to write any additional information about your current financial situation that you would like us to know such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

If you have questions or need help completing this application:

Our financial assistance policies, information about the programs, and the application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Translated written documents available upon request. To obtain contact information, please visit the website of the hospital or clinic where services were provided. Thank you.