Financial Assistance Application

Completing the application is not a guarantee you will be approved for financial assistance.

Patient's Name: _____ Date: _____

Employer: _____ Occupation: _____

Employer Phone: _____ Length of Employment: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Spouse's Employer Phone: _____ Spouse's Length of Employment: _____

Income Sources	**Monthly**	**Yearly**
Gross Salary	$	$
Spouse's Gross Salary	$	$
Other Income	$	$
Social Security Income	$	$
Other Compensation	$	$
Total Income	**$**	**$**

I, _____, hereby request that Haggard Chiropractic makes a determination of my eligibility for financial assistance. I understand that:

- My application will be reviewed for final determination only after all other possible payment resources have been considered which may assist me in support of medical expenses. Financial assistance will be reversed if I become eligible for or receive any third-party funding source to include liability or personal injury protection funding.
- I am required to report all income received, including gross taxable and non-taxable income which supports annual income.

I further understand that all disclosed income will be considered for determination of financial assistance and will not be released without proper consent.

- Financial assistance can only be applied to Haggard Chiropractic accounts.
- All of the information which I have provided to Haggard Chiropractic is true and correct to the best of my ability. I further understand that if any of the information is found to be false, my financial assistance may be denied.

Signature: _____ Date: _____