VALLEYGATE DENTAL SURGERY CENTERS
FINANCIAL HARDSHIP FORM

For this request to be considered the patient must have a sliding fee discount application on file. Sliding fee application must be attached with this request.

(Print of Type)
Patient Name: _____ ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

For the reasons checked and explained below, I am unable to pay the unreimbursed medical charges due to economic hardship. In addition, I do not have a guardian or other responsible party who can assist me with these expenses.

Please explain: (*Select all that apply*):
Unemployed No insurance Dependent on family for support Low or fixed income Student High medical expenses Bankrupt Not covered by state or local welfare program Other:

Explain:
_____
_____
_____
_____

_____ _____
Patient / Parent or Guardian Print Date

_____
Signature of Patient / Parent or Guardian
****

Administrative Use Only:
Based on the information stated above the patient _____ has been approved to receive the following financial assistance due to financial hardship.
____ Discount Rate of $ _____ _____ Rate Waived

____ Payment Plan of $ _____ deducted every month on _____ day will end on

_____ / _____ / 20 _____ Down payment: $ _____

____ Approved By: _____ Date: _____
Virginia Jones, PhD, CEO or designee