

# **Action Brace & Prosthetic, Inc.**

## Patient Hardship Form

It is the policy of Action Brace and Prosthetic, Inc. to collect financial information from our patients who communicate a hardship, so that we may determine how their account will be paid. Upon receipt of this information, a representative of our office will contact the guarantor to make payment arrangements. Our goal is to accommodate our patients with the best all around care we can give. Thank you.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Account #: \_\_\_\_\_ Dependents: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

Rent/Mortgage Payment: \_\_\_\_\_ Electricity: \_\_\_\_\_

Moblie Home Lot Rent: \_\_\_\_\_ Gas: \_\_\_\_\_

Food/Beverage \_\_\_\_\_ Sewer: \_\_\_\_\_

Telephone: \_\_\_\_\_ Water: \_\_\_\_\_

Prescriptions: \_\_\_\_\_ Other: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please describe in detail why you cannot pay. \_\_\_\_\_

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