	Financial Assistance Form		
Monthly Income: Please indicate all sources of income			
	Source		Amount
Patient:			$
Spouse:			$
Other:			$
Number of dependents			
	Total Monthly Income:		
	Gross:		$
	Net:		$
Monthly Expenses: Please indicate average expenses			
Rent /Mortgage:	$	Utilities:	$
Auto 1:	$	Telephone:	$
Auto 2:	$	Child Care:	$
Auto Insurance:	$	Groceries:	$
Health Insurance:	$	Medications:	$
Credit Cards (list)		Physicians (list)	$
Visa	$		$
MasterCard	$		$
Discover	$		$
Department Store	$		$
Other Credit Card	$	Other (list)	$
Other Credit Card	$		$
Total Expenses $			
Total Monthly Income: $			
Total Monthly Expenses: $			
Total Monthly Income minus Expenses: (Grand Total): $			
I certify the above information is correct and that payment of my liability would present a financial hardship.			
Signature of patient or guardian			