FHN APPLICATION FOR WAIVER OF FEES

Patient Name: _____ Patient DOB: _____
Encounter No. _____
Guarantor Name: _____
Address: _____
Health Insurance (if applicable): _____
Number of Household Dependents: _____
Name of Dependents:

_____ _____
_____ _____
_____ _____
_____ _____

Gross Monthly Household Income: _____
Total Monthly Household Expenses: _____

Rent/Mortgage Expense	$
Insurance (Total of Home/Auto)	$
Vehicle Payment/Lease Expense	$
Monthly Household Utilities Expense	$
Monthly Grocery and Household Supplies Expense	$
Monthly Medical/Pharmacy Expense	$
Total Monthly Household Expenses	$

Reason for Request to Waive Fees and Type of Documentation Provided:

_____
_____
_____
_____
_____
_____

As a patient of FHN, I have completed all information requested above to the best of my ability and declare the information to be accurate and true. I understand that any falsification of this information discovered will result in denial of request for Waiver of Fees related to this occurrence.

Patient/Guarantor Signature: _____ Date: _____

FHN Billing Representative: _____ Date: _____