# FHN Fee Waiver Approval Form

Patient Name: ______________________ Patient DOB: _________________
Encounter No. ________________
Guarantor Name: ______________________________
Address: ________________________________________________________
Health Insurance (if applicable): ____________________________________

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***Terms of Waiver***

The following terms have been agreed upon between FHN and _________________________ on ______________ (date) for a time period of ________________________. The terms of this agreement apply to this specific event and cannot be extended or transferred to any other patient or patient dependent fees or balance.

Clinic Location(s) of Services Received: _________________________________
Type of Services Rendered: ____ Medical _____ Behavioral Health _____ Dental
Date(s) of Services:
_____________________________________________________________________________________
_______________________________________________________________________

Total Amount of Patient Responsibility Due: $_________________

Total Amount of Patient Debt Waived $____________________

Reason for Waived Fees – See attached documentation.

Patient/Guarantor Signature for Acceptance of Terms:

__________________________________________________ Date: ___________________

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**APPROVED BY:**

_____________________________________ Date: _____________
Executive Director

______________________________________ Date: ______________
Chief Financial Officer