Impact Medical Services, LLC

FINANCIAL HARDSHIP INFORMATION FORM

NAME:_______________________________ AGE:________ DATE OF BIRTH:________________

SOCIAL SECURITY NO:________________________ MEDICARE NO:________________________

ADDRESS:____

OCCUPATION: _____________________________________ DOCTOR:________________

PLEASE FILL INFORMATION REQUESTED BELOW.
ALL INFORMATION WILL BE HELD CONFIDENTIAL BY Mobility First, Inc..

MONTHLY INCOME: ___________________________ SOURCE(S):___________________________

DO YOU OWN OR RENT YOUR HOME? OWN RENT MONTHLY PAYMENT_______________

DO YOU OWN A VEHICLE? NO YES MONTHLY PAYMENT____________________

PLEASE LIST AMOUNT OF ALL DEBTS THAT YOU OWE IN EXCESS OF $100.00:

PLEASE LIST THE USUAL MONTHLY EXPENSES: UTILITIES: ____________ FOOD:_____________

CLOTHING:_________ MEDICAL: _______________ TRANSPORTATION:____________________

OTHER (SPECIFY):____

ARE YOU ABLE TO PAY FOR ANY PORTION OF YOUR MONTHLY MEDICAL BILLS THAT ARE INCURRED THROUGH Mobility First, Inc.?

DO YOU HAVE ANY INSURANCE COVERAGE? PLEASE LIST BELOW:

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ON THIS FINANCIAL HARDSHIP INFORMATION FORM IS COMPLETE, TRUE AND ACCURATE.

CLIENT/PATIENT’S NAME (please print): ____

CLIENT/PATIENT'S SIGNATURE:____

DATE SIGNED:____________________________________