ProHealth & Fitness PT OT Physical/Occupational/APOS
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Date: ____/_____/_____

Patient Name: _____ Patient DOB: ____/____/____

I am requesting that you review my financial situation to see if I qualify for reduction or complete forgoing of my healthcare bill(s) with ProHealth.

I will have or am having problems making payments on my deductible/co-insurance/co-pay because of financial difficulties created by (check what applies):

- ☐ Reduced Income
- ☐ Unemployment
- ☐ Divorce
- ☐ Separation
- ☐ Medical Bills
- ☐ Too Much Debt
- ☐ Death of my Spouse
- ☐ Death of a family member
- ☐ Business Failure
- ☐ Job Relocation
- ☐ Illness
- ☐ Damage to Property
- ☐ Military Service
- ☐ Incarceration
- ☐ Other (Please specify) _____

This difficulty or situation happened on or about this _____/_____/_____

I believe that my situation is (circle one) Temporary / Permanent.

I (print name), _____, state the information provided above to be true and correct to the best of my/our knowledge.

_____
Patient's Signature

I, (printed name of ProHealth representative)_____, accept the above patient's request to (circle): **FORGO REDUCE** all healthcare bills associated with the services provided to the patient, other than payments made to the patient by their insurance company.

_____
Provider's Signature/Provider Representative Signature