



Tennessee Retina
 Attn: Medical Billing - Financial Assistance
 345 23rd Ave N STE 350
 Nashville, TN 37203-1596
 Phone: (615)983-6301
 Fax: (615)320-1213
 Email: _____

FINANCIAL ASSISTANCE APPLICATION

Please complete the application to the best of your ability, and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

Staff Use Only

PATIENT INFORMATION (PLEASE PRINT)				Account #	
<u>Patient Name:</u>	<u>Birth Date</u>	<u>Marital Status</u>	<u>Sex</u>	<u>Telephone No.</u>	
<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Email Address</u>	
<u>Social Security Number</u>	<u>Employer</u>	<u>Length of Employment</u>	<u>Hours worked per week</u>		
			Full Time / Part Time		
<u>Employer Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Employer Telephone No.</u>	

RESPONSIBLE PARTY'S INFORMATION

<u>Name:</u>	<u>Birth Date</u>	<u>Marital Status</u>	<u>Sex</u>	<u>Telephone No.</u>	
<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Email Address</u>	
<u>Social Security Number</u>	<u>Employer</u>	<u>Length of Employment</u>	<u>Hours worked per week</u>		
			Full Time / Part Time		
<u>Employer Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Employer Telephone No.</u>	

RESPONSIBLE PARTY'S SPOUSE INFORMATION

<u>Spouse's Name:</u>	<u>Social Security Number</u>	<u>Birth Date</u>	<u>Telephone No.</u>		
<u>Employer</u>	<u>Length of Employment</u>	<u>Hours worked per week</u>			
		Full Time Part Time			
<u>Spouse's Employer and Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Employer Telephone No.</u>	

DEPENDANTS INFORMATION

<u>Name</u>	<u>Age</u>	<u>Relationship</u>



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NET MONTHLY INCOME	
Applicant Earned Income	\$ _____
Applicant Spouse's Income	\$ _____
Social Security Benefits	\$ _____
Pension/Retirement Income	\$ _____
Unemployment Compensation	\$ _____
Worker's Compensation	\$ _____
Interest / Dividend Income	\$ _____
Child Support	\$ _____
Alimony	\$ _____
Rental Property Income	\$ _____
Food Stamps	\$ _____
Other	\$ _____
Other	\$ _____
TOTAL NET INCOME	\$ _____

Comments:

I hereby certify that the above information is true and complete to the best of my knowledge.

_____ Date

_____ Signature of Patient, Spouse, Guarantor or Legal Representative



Please return completed form to:
Tennessee Retina
Attn: Medical Billing - Financial Assistance
345 23rd Ave N STE 350
Nashville, TN 37203-1596
Phone: (615)983-6301
Fax: (615)320-1213
Email: _____

Today's Date: _____
Date Received: _____
Patient Name: _____
Patient Account#: _____

In order for us to assess your financial needs, you must fill out the attached form and provide All of the following applicable income documents:

- 1) Copies of last years tax return (you and your spouse if applicable)**
- 2) Copies of your last 3 months of pay stubs (you and your spouse if applicable)**
- 3) Copy of your Current Social Security Documentation (Letter)**

Printed Name: _____

Signature: _____

Date: _____