TENNESSEE RETINA

Please return completed form to:
Tennessee Retina
Attn: Billing Dept
345 23rd Ave N STE 350
Nashville, TN 37203-1596
Phone: (615)983-6302
Fax: (615)320-1213

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 #

Patient Name:	Birth Date	Marital Status	Sex	Telephone No.

Address	City	State	Zip	Email Address

Social Security Number	Employer	Length of Employment		Hours worked per week
			Full Time / Part Time	

Employer Address	City	State	Zip	Employer Telephone No.

RESPONSIBLE PARTY'S INFORMATION

Name:	Birth Date	Marital Status	Sex	Telephone No.

Address	City	State	Zip	Email Address

Social Security Number	Employer	Length of Employment		Hours worked per week
			Full Time / Part Time	

Employer Address	City	State	Zip	Employer Telephone No.

RESPONSIBLE PARTY'S SPOUSE INFORMATION

Spouse's Name:	Social Security Number	Birth Date	Telephone No.

Employer	Length of Employment		Hours worked per week
		Full Time Part Time	

Spouse's Employer and Address	City	State	Zip	Employer Telephone No.

DEPENDANTS INFORMATION

Name	Age	Relationship

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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. I hereby authorize Tennessee Retina to obtain information from external credit reporting agencies if Tennessee Retina deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

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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 BOTH of the following income documents:

1) Copies of last years tax return (you and your spouse if applicable)
AND
2) Copies of your last 3 months of pay stubs (you and your spouse if applicable)

Printed Name:_____

Signature:_____

Date: _____