



Please return completed form to:
Tennessee Retina
Attn: Medical Billing - Financial Assistance
318 Northcreek Blvd Suite 200
Goodlettsville, Tennessee 37072
Phone: (615) 983-6302
Fax: (615) 320-1213

Email: FinancialCounselors@tnretina.com

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

In order to assess your financial needs, you must fill out the attached form and provide any 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: _____



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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.

PATIENT INFORMATION (PLEASE PRINT)				<i>Staff Use Only</i>
Patient Name:				Account #
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.

_____ Date

_____ Signature of Patient, Spouse, Guarantor or Legal Representative