No Income/Support Verification

Date: ________________ SS# (if available)_______________________

Patient Name: ____

Current Address: ____

Date of Last Employment: ____

If you are not receiving any income from any source, we require this form to be signed.

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I, ______________________________ am not receiving any income from any source at this time. In addition, there are no third party payor sources to cover my medical services.

______________________________ ___________________________

Patient Signature Agency Rep Signature

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Notary Signature Date Notary Stamp

****

We require this form be signed by the individual assisting you in meeting your expenses.

I, ____, am assisting ____ in meeting his/her expenses. I am not claiming this individual as a dependent on my income taxes.

______________________________ ________________________

Signature of Party Providing Assistance Agency Rep Signature

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Notary Signature Date Notary Stamp