

No Income/Support Verification

Date: _____ SS# _____

Patient Name: _____

Current Address: _____

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

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

Patient Signature

Agency Rep Signature

Notary Signature

Date

Notary Stamp

We require this form to 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

Notary Signature

Date

Notary Stamp