Shreveport ∞ Minden ∞ Natchitoches ∞ Winnsboro

APPLICATION/AUTHORIZATION FOR FINANCIAL ASSISTANCE

Patient Name: _____ Phone _____

Social Security _____ Date of Birth _____

Street Address _____

City State Zip _____

Insurance Name _____ Policy # _____

Insurance Name _____ Policy # _____

Household Size _____ Approximate Gross Monthly Income _____

By signing below, I am stating I am unable to afford the treatment prescribed to me and give my permission and authorization to MD Clinics and their authorized representatives to pursue financial assistance, to request and complete applications and speak on my behalf regarding any and all assistance and agree to any unused medication to be donated to Compassionate Care for other patients in need of assistance.

I understand that signing this authorization is not a guarantee I will receive assistance.

Patient Name _____ Date _____

Witness Name _____ Date _____

∞ If form is not complete - including approximate gross monthly income – payment may be expected at time of treatment ∞