FINANCIAL DISCLOSURE

Patient's Name:____ Patient's Date of Birth: ____________________

GUARANTOR INFORMATION

Guarantor Name:____ Relationship: ____________________________

Address: ____ Home Phone: ____________________________

City:_______________________________ State:_______ Zip: _________________ Work Phone: ____________________________

\# of family members claimed on most recent Federal Income Tax Return: _______ Cell Phone: _____________________________

E-mail Address: ____ Social Security #: ________________________

INCOME

Gross Yearly Household Income: Please include income from all members that live in the same household and all forms of income (work, alimony, child support, dividends, etc.) $ _____________._______

Other household financial resources (stocks, savings, inheritance, etc.) $ _____________._______

ATTACHMENTS

Please include most recent Federal Income Tax Return and/or most recent paycheck stub(s)

MISCELLANEOUS

Please include any other financial information that would be of importance in consideration of your request for a reduced fee:

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I attest that the information disclosed above is true and accurately reflects my current financial situation. I further attest that I do not have any mental health benefits through any insurance plan for the treatment I receive at Meier Clinics®. I authorize Meier Clinics to obtain credit reports or other financial confirmation as they deem necessary to verify financial need. If my financial status changes or I obtain insurance coverage, I will notify Meier Clinics immediately. I further acknowledge that I must update my information every six months for consideration of continued reduced fee services.

Guarantor's Signature: ____ Date: ______________________________

MC STAFF USE ONLY

Location/Program:_________________________ Acct. #: _________________________ Amount Approved

Reviewed by: ____________________________ Date: ___________________________ $_______________

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