Today's date: _____

Request for Financial Help

Name: _____

Date of birth: _____ Gender: _____

Email: _____ Phone: _____

Address:_____

I request help for my outstanding bill of _____ as I am undergoing financial hardships.

My last date of service was: _____

I request you give me a discount of _____. Remaining amount of _____, I can pay via

_____

I will like set up a payment plan, with following details:-

_____

I agree that Dr. Ashok Patel, Ashok PC, Academy Allergy Asthma and Sinus Center has full right to accept, reject, or modify the above request with or without giving any reason. In case of rejection, I am liable to pay my outstanding bill amount.

Patient Name: _____

Patient Signature: _____

Witness Name: _____

Witness Signature: _____