



Financial Intake Form

Name: _____ Account Number: _____
SS# _____

INSURANCE INFORMATION

None Medicare Medicaid Private _____ HMO _____
Other _____

EMPLOYMENT HISTORY

Full Time Part Time Unemployed Effective Date: _____
Retired

Name of Employer: _____ Income: _____

INCOME ASSISTANCE

If unemployed or suffering economic hardship, have you applied for assistance? Yes
No

Type of assistance: _____ Approved Yes No If no, why?

Type of assistance: _____ Approved Yes No If no, why?

Type of assistance: _____ Approved Yes No If no, why?

OTHER INCOME

AFDC/TCA \$ _____ Child Support \$ _____ Alimony
\$ _____

Work Comp \$ _____ Rental Income \$ _____ Retirement
\$ _____

Disability \$ _____ Food Stamps \$ _____ Other
\$ _____

EXPENSES

Mortgage \$ _____ Rent \$ _____ Electric \$ _____
Phone \$ _____

Insurance \$ _____ Food \$ _____ Car \$ _____
Credit \$ _____
Other _____ \$ _____ Other _____ \$ _____ Other
_____ \$ _____

TOTAL HOUSEHOLD DEPENDENTS: _____

TOTAL HOUSEHOLD INCOME: \$ _____

(-)
TOTAL HOUSEHOLD EXPENSE: \$ _____

(=)
TOTAL AVAILABLE: \$ _____

Signature: _____

Date:

The above information is true and correct to the best of my knowledge. I authorize Diabetes & Endocrine Associates, LLC to verify any of the above information.

OFFICE USE ONLY

Based on the above information the request for reduced fees have been: Approved
Denied

For the term of: 3 months 6 months 9 months 1 year Other

Practice Manager: _____

Date: