WILLAMETTE UROLOGY, P.C.
FINANCIAL ASSISTANCE APPLICATION

The doctors at Willamette Urology, P.C. want to be understanding of patient's abilities to pay their debt. We would like to work with you to establish an agreeable payment plan. We would like to work with you to avoid having to send your account to a collection agency.

PLEASE COMPLETE ALL SECTIONS OF THIS APPLICATION

Patient Name	**Telephone Number**
Address:	
INCOME INFORMATION	
Name of Person Responsible for Bill	Spouse (if applicable)
Address of Person Responsible for Bill if different from patient address:	
Employer of Person Responsible for Bill:	Employer of Spouse:
Job Title:	Job Title:
Earnings per week:	Earnings per week:
Social Security Income:	Other Income:
Number of People living with you that are dependent on your income: Names and ages:	
Currently Receiving any public assistance? Yes____ No ____	Have you ever received public assistance? Yes____ No ____
OTHER ASSETS	
Savings Account Bank Name	Checking Account Bank Name
Balance in Savings Account $	Balance in Checking Account $
Value of House (if owned) $	Value of Stocks or Bonds you Own $
Value of any other Property Owned $	Value of Cert of Deposit you Own $
Car(s)/Truck(s) Value $	Motor home/snowmobile or other $
List other assets and their value	

MONEY OWED PER MONTH			
Mortgage/Rent	$	Food	$
Utilities-Electricity,Water,Gas	$	Car Payment	$
Gas, Repairs, Insurance for Car	$	Prescriptions	$
Doctor Bills	$	Hospital Bills	$
Health Insurance	$	Cable, Satellite, Cell Phone	$
Child Care	$	Credit Cards (List)	$
Loans (List)	$	Other (Explain)	$

I understand that Willamette Urology, P.C. may verify this information. I certify that the above information is true and complete.

Signature of person responsible for the bill_____

Date_____

In order for our office to work with you in determining a reasonable monthly payment on your outstanding debt, please provide the following items. If we do not receive all of the items requested your application will be considered incomplete.

_____ **Copy of your Federal Tax Return (form 1040 or 1040EZ) from the previous year and W2's**

_____ **Copy of your business tax return from the previous year, if you are self-employed**

_____ **Copy of last 2 payroll check stubs, social security checks or other income checks**

_____ **Copy of your last two months bank statements including checking and/or savings account**

_____ **If you have recently applied for Medicaid and were denied, include a copy of the denial letter from Medicaid**

Mail the completed application with the items requested above in an envelope marked "Confidential" to:

Willamette Urology, P.C.
Attn: Business Office
2973 12th Street SE
Salem, OR 97302

Please allow 30 days for review. After review, we will contact you and discuss payment options. If you do have an account balance, please continue to make monthly payments while we review your information or contact our office accordingly. If you have any questions, please call our billing office at 503-561-7115.

Willamette Urology, P.C.
Payment Reduction Policy

For patients who have had:

- **Charity applications approved for a reduction in their bill (bills not paid in full with the charity application)**
- **A reduction in the cost of their services because they are considered self-pay and the patient requested a reduction to their bill**

Willamette Urology, P.C. will request that the patient complete the attached form, agreeing to make monthly payments on their remaining reduced balance. As stated on the form, failure to return the form or failure to make an agreed upon monthly payment will allow Willamette Urology, P.C. to reconsider the reduction of costs for previous services and possibly reverse the reduction in the cost of services.