NEUROTECH©®
EEG Specialists

Patient Request for Financial Assistance

I hereby request that Neurotech, LLC make a determination of my eligibility for financial assistance for services provided to be me and/or members of my family.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

DATE(S) OF SERVICE: _____

APPLICANT/GUARANTOR INFORMATION:

Name: (Last, First, MI)	**Soc Sec No.**	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Date of Birth	**Home Phone**	**Cell Phone**
Home Address		
Employer:	**Position/Title**	**Employer Phone**
Employer Address:		
Salary **Week $**_____ **Month $**_____ **Year $**_____		

SPOUSE:

Name: (Last, First, MI)	**Soc Sec No.**	
Date of Birth	**Home Phone**	**Cell Phone**
Home Address		

Employer:	**Position/Title**	**Employer Phone**
Employer Address:		
Salary **Week $**_____ **Month $**_____ **Year $**_____		

FAMILY INFORMATION:

List children under the age of 18 for whom you are legally responsible:

Child's Name: (Last, First, Middle Initial)	Age:	Relationship:	Child reside with you?

HOUSEHOLD INCOME:

APPLICANT AND SPOUSE'S MONTHLY INCOME:

WAGES: $_____

SOCIAL SECURITY: $_____

ALIMONY BENEFITS: $_____

CHILD SUPPORT: $_____

PENSION BENEFITS: $_____

OTHER INCOME: $_____
(SOURCE):_____

TOTAL: $ 0.00

OTHER ASSETS:

SAVINGS: $_____

CHECKING: $_____

INVESTMENTS: $_____
(STOCKS/BONDS/CD)

RETIREMENT ACCTS: $_____

TOTAL: $ 0.00

INSURANCE COVERAGE:
Does the patient have medical insurance coverage? ☐ Yes ☐ No

If "Yes," please list responsible party information: (Please include a copy of insurance card.) Insurance Carrier Name: _____
Insurance Carrier Address: _____
Insurance Carrier Phone Number: _____
Policyholder Name: _____ ID#: _____

ADDITIONAL INFORMATION:
(Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

Please provide last years federal and state income tax return with W-2 form and wage payment stubs for the last two pay periods.

I HEREBY CERTIFY THAT ALL OF THE INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT. I AUTHORIZE NEUROTECH, LLC TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFIED AND NEUROTECH , LLC WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

Responsible Party Signature: _____ (print and sign)

Responsible Party Name (Print):_____

Date: _____

Return Application and Supporting Documents to:

Neurotech, LLC
Attn: Billing Dept
626 W. Moreland Blvd
Waukesha, WI 53188