FINANCIAL HARDSHIP AGREEMENT

PATIENT

ADDRESS:

CITY AND STATE:

PHONE:

EQUIPMENT AND/OR SUPPLIES:

I, agree that my portion of

$ for the equipment/supplies named above represents a financial hardship. I agree to pay Gateway Medical Supply $ , with the remainder of $ to be written off by Gateway Medical Supply. I understand that I am totally responsible for any additional charges which may arise as a result of price changes, addition of equipment/supplies, Medicare and insurance deductibles and amounts not covered by insurance.

Signature of Responsible Party Date

Organization Representative Date