# Premier Medical Group of the Hudson Valley, P.C.

## Financial Need Form

Return form to PMGbilling@caduceushealth.com

**Patient Information**

Patient Name:

Address:

City/State/Zip:

**Responsible Party (if different than patient)**

Name:

Address:

City/State/Zip:

**Do you currently have insurance coverage? If yes, please indicate the type:**

☐ **Medicare** ☐ **Medicaid** ☐ **Commercial**

**Please indicate your current employment status:**

☐ **Full-time employed** ☐ **Part-time employed** ☐ **Not currently employed**

Occupation:

Employer Name:

Employer Address:

Employer Phone:

**Please list your Adjusted Gross Income: $**

Family Size:

☐ **Your Income** ☐ **Spouse's Income** ☐ **Other Household Income**

**Financial Situation / Monthly Expenses / Special Circumstances**

**Certification Statement**

I certify/attest that the information provided above is, to the best of my knowledge, true and accurate. If requested by Premier, I will provide the necessary documentation to support the information provided on this form. I further understand that any waiver/reduction determination made by Premier applies only to the amount indicated below, and only for the services and care provided to me on the date specified below. Any future medical expenses are not included in this determination, and will be made on a case-by-case basis.

☐ I certify the statement above.

Signature

Date