NEUROBALANCE
CENTER

Request for Financial Assistance

To process your application the following documents must accompany this application:

1. Copy of the first and second page from your most recent tax return.
2. Copies of the last 2 pay stubs, social security and disability checks for EACH adult in the household.

Applicant _____ Date _____

Phone _____ Alternate Phone _____

Home Address _____

Adults living in household _____
Dependents living in household _____

For which of the following are you seeking assistance? (circle)

- Counseling
- Chiropractic
- Physical Therapy
- Fitness classes
- Power Plate®
- Acupuncture
- Massage Therapy
- Nutritional Counseling
- Other

Describe any debt you'd like us to consider? (consu mer, medical, loans)

_____
_____

Describe your circumstances/reason for applying for financial assistance including any extraordinary expenses we should take into consideration.

I feel I am able to pay $ _____ toward the cost per visit/service/program.

For this request to be considered, submission of this completed form and requested documents is required.

I certify that the above information is true and complete to the best of my knowledge. I agree to inform the fitMS NeuroBalance Center immediately in my income or family size. I understand that false or incomplete information could jeopardize my financial assistance.

Signature _____ Date _____