NEUROBALANCE
CENTER

ACCESS FOR EVERYONE

Request for Financial Assistance

Applicant _____ Date _____

Phone _____ Alternate Phone _____

Home Address _____

Annual Individual Income _____

Annual Household income_____

Adults living in household _____

Dependents living in household _____

Please describe your circumstances/reasons for apply for financial assistance including any extraordinary expenses we should take into consideration.

_____

_____

_____

_____

_____

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

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

Signature _____ Date _____

AMDINISTRATION ONLY:
Services_____APPR_____Date_____