LIFE IV Medical Weight Loss

(517) 273-3210
lifeivweightloss.com

Financial Assistance & Payment Plan Application

Life IV Medical Weight Loss · Confidential

How to submit this application:

- Complete all fields on both pages and sign where indicated on page 2.
- Attach proof of income: pay stubs, tax returns, SS award letters, or other verification.
- Email to financial.assistance@lifeivweightloss.com or return in person to our office.
- All information is strictly confidential and used only to determine payment plan eligibility.

PATIENT INFORMATION

TODAY'S DATE | ACCOUNT / VISIT # (IF KNOWN)

FIRST NAME | LAST NAME | LAST 4 SSN

DATE OF BIRTH | MARITAL STATUS (S / M / W / D) | GENDER

STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | EMAIL ADDRESS

RESIDENCY & ELIGIBILITY

Are you a United States citizen or legal resident?	☐ Yes	☐ No
Have you been a Michigan resident for the past 6 months?	☐ Yes	☐ No
Do you currently have health insurance?	☐ Yes	☐ No
Have you applied for Medicaid or Medicare?	☐ Yes	☐ No

IF YOU APPLIED FOR MEDICAID / MEDICARE — WHAT WERE THE RESULTS?

HOUSEHOLD

TOTAL PEOPLE IN HOUSEHOLD | NAMES AND AGES OF ALL HOUSEHOLD MEMBERS

FINANCIAL SUMMARY

TOTAL GROSS HOUSEHOLD MONTHLY INCOME (ALL SOURCES COMBINED — $)

TOTAL CHECKING / SAVINGS / RETIREMENT BALANCES (APPROXIMATE — $)

HOUSING / RENT | UTILITIES | TRANSPORTATION | FOOD | MEDICAL / OTHER

INSURANCE (complete if applicable)

INSURANCE COMPANY NAME | POLICY # | GROUP #

INSURANCE COMPANY ADDRESS | INSURANCE PHONE #

EMPLOYMENT HISTORY (past 12 months)

List all employers for patient and spouse over the past 12 months.

Patient / Guarantor:

EMPLOYER NAME	DATE HIRED	DATE ENDED (OR "CURRENT")

Spouse (if applicable):

EMPLOYER NAME	DATE HIRED	DATE ENDED (OR "CURRENT")

HOUSEHOLD INCOME DETAIL

List all household members who receive income. Enter $0 if none. Leaving fields blank may delay processing.
"Family" = patient, spouse, and dependent children under 18 living in the home.

Name	Age	Relation to Patient	Gross Income 3 Mo. Prior	Gross Income 12 Mo. Prior	Current Gross Monthly Income	Income Type
SELF						

TOTAL PERSONS IN HOUSEHOLD	TOTAL COMBINED HOUSEHOLD ANNUAL INCOME ($)

PAYMENT PLAN REQUEST

Describe the payment arrangement you are requesting. Our team will review and contact you to confirm.

BALANCE OWED ($)	REQUESTED MONTHLY PAYMENT AMOUNT ($)

ADDITIONAL NOTES OR EXPLANATION TO SUPPORT YOUR REQUEST (OPTIONAL)

CERTIFICATION & SIGNATURES

Certification Statement

By signing below, I certify that all information provided is true, complete, and accurate to the best of my knowledge.
I understand that providing false or misleading information may result in denial or reversal of any payment plan.
I authorize Life IV Medical Weight Loss to verify the information provided as necessary to process this application.

Patient / Guarantor Signature	Date	Spouse Signature (if applicable)	Date

Staff Member Signature (if applicable)	Date	Staff Member Print Name & Title	Date

Questions? Email financial.assistance@lifeivweightloss.com or call (517) 273-3210
Return in person: 5433 S. Occidental Hwy Ste C, Tecumseh, MI 49286