REQUEST TO WAIVE COPAYMENT OR DEDUCTIBLE

Patient's name _____ Medical record # _____

Address_____ Account # _____

City/State/Zip _____

Description of services to be provided _____

I hereby declare that I cannot afford to pay Haven Counseling the copayment and/or deductible for the above-

described services because my gross family income is at or below 200 percent of the current federal poverty guide-

lines, as described in Haven Counseling's Waiver of Patient Copayments or Deductibles Policy.

I therefore request a waiver of the copayment and/or deductible for these services. I agree to notify Haven

Counseling if my gross family income rises above 200 percent of the current federal poverty guidelines, at which time

I will begin to pay any required copayments or deductibles.

I declare under penalty of perjury that the above is true and accurate. Patient's signature

_____Date_____